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Serving California's Latinos and Other People of Color

An Inside View From the "Healthcare Front Lines." Also a Summary of Services and Strategies Designed to Provide Access to Limited English Proficient (LEP) Populations by Various public and Private Health Agencies and Systems in California

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LATINO COALITION FOR A HEALTHY CALIFORNIA

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Many people participated in gathering information and sending me descriptions of their organizations and other materials. I am especially grateful to those who participated in the focus group sessions or who responded to surveys. Their candid responses give us some insight into the challenges they face every day in their attempts to serve the underserved Limited English Proficient Latino and other people of color. The time taken for these tasks was given generously and this project could not have been completed without their support.

Lia Margolis, President and CEO
Lia Margolis and Associates
Prepared on Behalf of the Latino Coalition for a Healthy California

The information, views and opinions expressed herein are those of the author and do not necessarily represent the official position or policies of LCHC.

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BACKGROUND

In the summer of 2001, the Latino Coalition (LCHC) embarked on a task to identify a sample of various types of Culturally and Linguistically Appropriate Services (CLAS) for Limited English Proficient (LEP) patients in California. More importantly, the goal was to get a sense of the feelings of the people who serve Latinos and other people of color in health care settings in a state that is one of the most diverse in the nation. The project was funded with a grant from the Department of Health and Human Services, Office of Minority Health. As part of this process, eight focus sessions of diverse providers were conducted to determine:

- Their understanding of the federal CLAS standards,
- The extent they were aware of the Language Access requirements under the Medicaid (Medi-Cal in California) and State Children's Health Insurance Program (SCHIP-Healthy Families in California) programs, the two largest federal programs impacted by CLAS,
- Their perspectives on the extent of the diversity of the population in California and to get their reaction on how this impacted the health care setting,
- Their views on the need to increase diversity in the health professions and other related services and activities
- Programs or Language access services that either they or others were providing to limit barriers to LEP populations.

Most importantly, the sessions were designed to allow for candid and open discussion on the issue from various perspectives especially from those who serve on the front lines of the health care setting.

In advance of these sessions the Introduction and overview of the CLAS and LEP issues that follows (Page 8) was shared with focus group participants so that discussions could flow more readily and participants could refer to current information on the issue. The document purposely drew no conclusions merely stated what existed in California at the time of the sessions. The paper was designed to provide "points for discussion." A number of questions were asked of the participants to elicit candid assessments and perspectives on each element of information on the CLAS standards and Limited English Proficient barriers that impeded access in health care settings. The focus group activities were conducted in a number of venues and healthcare settings and included:

- LCHC Regional Network Meetings
- Community Based Health Centers
- Health Maintenance Organizations
- Public Hospitals and Clinics
- Community Based Social and Human Services Organizations

- Latino and Health Access Advocates Organizations
- Focus Groups of Solo Providers (including nurse practitioners)

Most of the focus groups were small (eight participants or less) and most of the participants asked not to be specifically identified. They wanted to preserve their identity so that they could honestly and candidly share their views on the changing demographics in California. They wanted to speak openly about the barriers and challenges that are inherent in meeting the needs of vulnerable, limited English speaking people in health care settings. The focus group sessions were held over the course of a year. The focus group sessions were facilitated by Lia Margolis. The names of participating organizations were shared with the Office of Minority Health, DHHS.

In keeping with our promise to those who were interviewed, we will not reveal the names of the individuals or organizations interviewed as part of this project. The candid and telling information drawn from this process gives some indication of the concerns that are emerging as health care providers struggle to keep pace with the needs of diverse, limited English or monolingual populations. The summary follows in the order of topic in the paper prepared by LCHC, "Culturally and Linguistically Appropriate Services (CLAS) Standards - Points for Discussion." Each participant was asked to read the paper prior to participating in the focus group sessions (Copy of the paper appears on page 19).

About The Focus Group Participants

It would have been easy to select a number of "experts" in the field and draw upon their expertise to gain similar knowledge. However, it was felt there was a need to put an ear to the ground and find out what was happening right on the front lines of health care settings. The focus group participants were drawn from interpreters, physicians (in corporate, non-profit and solo practices), nurse practitioners, nurses, allied health and clerical services. Mid-level administrators who take call at night and who deal most directly with the challenges of addressing the needs of LEP clients every day were hesitant, but supportive respondents. Included were community based advocates who not only serve as advocates against health systems that don't comply, but who also work closely with providers and see these issues first hand.

The intent was to provide a view from the front lines drawing from perspectives that came from what might be viewed as a conflicted place. These are people who serve loyally and willingly but share a burden that is often heavy. They do not have time to take a respite and reflect on what is happening to LEP clients because they are so busy trying to

accommodate this vulnerable population's needs. A good number of them would be taking risks if they stated how they truly felt about this issue in their workplace or in other venues. They were grateful for the opportunity to be candid, forthright and honest. We are grateful for their trust and willingness to share with us. They are the true unrecognized force that is valiantly *…Serving California's Latinos.*

FOCUS GROUP AND MEETING SUMMARIES

The following is a summary of the group discussions. The questions given to each focus group or audience will precede each section of the summary responses. This process was to elicit "antidotal" and empirical comments from a broad cross section of providers, advocates, social service agencies and others who serve California's Latinos and other people of color. This is not a scientific study, but the summary responses are an indication of the challenges presented in meeting the needs of Limited English Proficient populations. As a result of this first foray into the front lines it is apparent that much more structured research is needed to formally document this dynamic. The intent of the project and design was focused on providing a forum for preliminary, candid discussion. The participants just welcomed the opportunity to speak freely on the topic, unfettered by a more formalized structure and free of challenges to, or immediate analysis or criticism of their views. The participant's desired outcome was that there would be more such open dialogue. It is their hope that these candid revelations provide a better understanding of this challenge and ultimately to better services.

Implications for Health Access

Question:

The paper we gave you presented some of the implications to access that Limited English Proficient (LEP) patients face in health care settings. The paper indicates that health care is the outcome of the interaction between the two fundamental processes - access and utilization - of health care services. Further, analysis have linked language barriers or limited English proficiency with fewer physician visits and reduced receipt of preventive services, even after controlling for such factors as literacy, health status, health insurance, regular source of care and economic factors. Several other barriers exist for LEP persons. Do you agree or disagree? What has your experience been, and can you confirm or deny that such barriers exist?

Summary Response

There was a consensus that LEP individuals do face greater barriers that limit their access to care. However, there was a varying degree of concurrence on the level and kinds of barriers that existed. It was felt that while there are barriers, most solo providers, health maintenance organizations and clinics felt that efforts to hire interpreters and translate materials for most high utilization and/or, at a minimum, threshold language populations had increased dramatically over the past five years. It was felt there was not an overt attempt to deny services because of a person's limited English.

The number of newly emerging populations that are fewer in numbers were of concern to most respondents because it was more difficult to find health care professionals and/or interpreters for less frequently required languages. It is even more difficult to hire, for example, an interpreter for a language where the number of times the language services are required are less than two or three times per week. Regrettably, more often than not, in those instances, language line services are more widely used. If an interpreter is used, they usually charge a minimum rate/hours, and may require that mileage or transportation costs also be reimbursed. This also means the patient must wait until the interpreter is available. Language lines are expensive, but may be less costly than securing an off-site, less frequently used language interpreter and incurring related costs. In most cases if an interpreter has to be called in, the patient waits less time with a language line.

It was noted in several groups, most frequently in the health advocacy but also in the providers groups that providing language access services was a "cost of doing business." While this was relatively accepted, there was also the argument posed that, if in fact, providers did not provide health care to LEP populations for which they had little or no language services for, those populations might not have any other place to go. Most often, these are immigrant populations that start in small numbers in a community and over time, grow in numbers. However, their group numbers may not ever be considered a threshold language population. Providers are faced with a real dilemma because they may want to serve newly emerging LEP populations, but the resources required to serve are non-existent and/or not reimbursed under the current system of capitation on rates. Over time, this could lead to such populations not being served at all.

Efforts to address this issue have to be more aggressive in an environment where access to all other health services is limited as well. The setting of priority for <u>all</u> types of health services and programs leaves

language access on a lower rung. Since the numbers of diverse populations are growing, the problem needs to be addressed so that provider and patient are not left at odds are at a disadvantage.

Diversity of the State and Language Diversity

Question:

California's population is undergoing dramatic racial and ethnic change as it evolves from a largely white state to one with a much more diverse population. In 2000, the US Bureau of the Census designated California a majority-minority state, as the proportion of the state's White population fell below 50 percent. The California Department of Finance estimates that by the Year 2020, half of the state's population will be Latino and Asian American. In 40 years, whites are expected to represent only one-third of the population, while Latinos, African Americans, and Asians will account for two in three California residents.[1]

California is the most linguistically diverse state in the nation, with more than 200 languages and innumerable dialects. Were you surprised by the numbers quoted in the LCHC paper on the diversity of the populations and languages in the State of California?

Summary Response:

Very few respondents seemed surprised about the diversity of the state. However, respondents were surprised by the fact that Whites were no longer a majority and that people of color were now in the majority as designated by the US Bureau of Census. The numbers on the language diversity were the most surprising for the respondents. They had suspected that the number of languages were high, but did not realize the exact number.

There was concern for the "non-threshold" Limited English Proficient populations that are fewer in numbers but no less needy. The default, in the instances where there is not an interpreter readily available, is the Language Line. There are still instances where a family member is used (whenever possible avoiding using children), often with the patient's permission, but that option is not the first choice.

In the Latino population newly emerging language groups are the Mexican "Zapateco," "Mextico" and others who come from the indigenous rural Mexican and South American countries. Language access limitations can be further compounded for these populations by the difficulty they have reading materials. Many are not relevant because they are not in their language even if they are translated into Spanish. For other Spanish

[1] *Finding Common Ground: Race and Ethnic Attitudes in California,"* Public Policy Institute of California, San Francisco, CA 2001

speaking Limited English Proficient populations, even at fourth grade level, written materials may be above their reading capability. This is also true with other communities of color and indigenous populations. Most providers, governments and social agencies feel that translating materials into Spanish meets the needs of Latino populations which is not necessarily the case.

One other concern is a new burden on the "Language Proficient" employee. They speak another language and they are often called upon to serve as an interpreter even though this is not a requirement of their job. They are not necessarily compensated for the additional service and must provide the language service at the expense of duties that are required of them jeopardizing their standing and job performance. When they refuse to provide the service, they may be chastised or criticized for not being supportive of "their people," creating added pressures on the job. Employers must be made aware of this problem so that they can avoid this form of job stress for Latinos and other bilingual staff.

Major Health Programs - Medi-Cal and Healthy Families

Question:

When compared to all ethnic groups, Latinos depend on Medi-Cal, California's Medicaid program and the Healthy Families Program (SCHIP) significantly more than any other group. Medi-Cal provides health coverage to over 6 million California poor working families, disabled, and elderly persons. Twenty-six percent of the Latino community or 2.3 million individuals rely on Medi-Cal and Healthy Families for health coverage.[2] For those with a family income less than 100% of the federal poverty line, almost half are enrolled in the Medi-Cal program. Over 30 languages have been identified but many more language needs exist. What strides have been made in meeting this need? Does there need to be more done, and if so, what?

Summary Response:

There was a feeling most expressed by providers that they were not doing enough. Certainly with such a great need, there is always room for improvement. However, they did not perceive that the efforts they undertook to address the issue were always recognized or appreciated. Also they felt that there is not sufficient recognition that in emergent situations, the frustration of the provider when they cannot understand is just as confounding as the patient's inability to express their symptoms, pain, or concern. Even when the health situation is not emergent, seeing the patient wait while an interpreter is found for a less spoken language is

[2] UCLA Center for Health Policy Research, "*The State of Health Insurance in California,*" Findings from the 2001 California Interview Survey.

frustrating because the provider is willing to serve. However, they may not want to take the risk of treating without fully understanding the patient's needs, symptoms or concerns.

Medi-Cal and even Healthy Families patients have through these programs gained a greater means of coverage for health care. They have a wider choice of providers but that does not ensure that they have access to language services. Medi-Cal patients are lower income, often working families and tend to delay health care until the need is greater or emergent. This occurs for varying reasons – often they cannot afford to miss work. Healthy Families clients may not know about all the benefits of the program and the choices they have in coverage. Those with limited English proficiency know even less. In either program, limited English patients are seldom aggressive health care consumers and this serves to their disadvantage in the health care setting.

Language access services are provided unevenly and can be great in one health care setting and abysmal in others. Advocates feel they have to push aggressively for more and consistent services even if some providers are doing a good job. While there are provisions, guidance and policy to support greater language access, there does not seem to be a consistent enforcement entity to ensure that those who provide services to limited English clients meet language access requirements. Until that situation changes, advocates say they will be there to provide a safeguard and to motivate more improvement and supportive change for Limited English populations.

When the economy slows, there is a greater need for entitlement and support services like Medi-Cal and Healthy Families programs. Ironically, traditionally these are the first programs offered up as budget cuts. While there is a growing recognition that language access services are a severe need, the numbers of minority and language proficient employees are not sufficient in numbers comparable to the need. The burden then, shifts to those few who do have the language skills – or worse yet, the service is not provided.

All agreed much more needs to be done. More and more health systems and agencies are recognizing the value of meeting the needs of the limited English patient and the risks they take as caretakers when they do not. There is competition for Medi-Cal and Healthy Families clients so language access services are seen as a draw. Unfortunately, there is not now in California any reimbursement mechanism to pay for language access services. With overall reimbursement rates lower than more than 40 other states, this is unlikely to change any time soon. If and when

increases in reimbursement are offered, the trend is to push for increases in reimbursement for direct patient care, not language access services.

The Uninsured

Question:

Diverse populations represent the largest numbers of uninsured in California. The providers who care for the uninsured are often the same providers who serve the Medi-Cal population. These hospitals, clinics and physicians in the past, used the income from the Medi-Cal program and other third party payers to subsidize uncompensated care. However, the advent of managed care and the flat growth rate of Medi-Cal rates are threatening providers' ability to cross-subsidize care for the uninsured. What impact is this having on providers who by mission or regulation provide services to the uninsured?

Summary Response

Regrettably, the uninsured have become the most serious problem in the health care setting. Most often they are people of color and have come to rely on safety net providers at the same time that support for such institutions is being threatened by budget and other fiscal constraints. Those with a mission to serve the poor will continue to do so. While there have been gains in access and a greater choice of providers, for Medi-Cal and Healthy Families over recent years, as the uninsured populations grow, the limited reimbursement of these two programs cannot accommodate any shifting to those without health care coverage. At the same time, both public and private sector health care providers are leaving the ranks of Medi-Cal and Healthy Families because of the poor reimbursement, threatened cuts to existing programs and their inability to maintain their revenue base if they continue such service.
The uninsured then, are reduced to:

- paying cash for services rendered,
- using emergency rooms because they delay care to such an extent that the health problem is emergent when they finally seek service.
- using swap meets to get medication from unlicensed, unqualified vendors who often sell outdated pharmaceuticals and give untrained medical advice.
- seeking care from unlicensed and unqualified storefront or neighborhood caretakers who prey on such populations.
- receiving health care where the provider is qualified but takes advantage of the uninsured by charging more for the services.

It was felt that both the uninsured patient and those whose mission it is to serve them are victimized in a health system that both government and the

health care industry seem to condone. While there have been studies to document the value of preventive and primary care as the first line of defense against injury and disease, reimbursement for such services are at the lowest sources of revenue. As the American health system exists today, there is a reward for incurring injury and disease and addressing it at the highest end of the health care dollar. At this high cost end of the healthcare spectrum, resources and expenditures for language access regrettably often become a luxury by default. Even so, most emergency rooms do make greater attempts at securing language access capacity because of the greater risk inherent with health emergencies and the compounding liability of not knowing what ails the patient when they are most at risk.

Several respondents indicated it is confounding that the forums that exist to solve the problem are focused on the "problem of the uninsured," not on the need to structure health systems with an emphasis on being and staying well rather than reacting to injury and disease at crisis and high cost. Addressing the needs of the uninsured should not be viewed as a result of a negative systematic consequence. It should be a foremost concern as an issue of equity in the healthcare setting. Lack of funds should not be a determinant factor in the categorization or level of service rendered.

There needs to be a greater understanding that solving this problem has to come from a perspective that is broader and that looks at the entire health care system, how it is structured, how it is financed, its responsibility to the patient and the patient's rights and responsibilities in using it. It was felt such an assessment will require greater collaboration between all parties whether, provider, advocate, government, patient or other interested parties. It is often easier to think that there is one evil force denying access to care. The evil here is not any one entity. It is ignorance on all sides of the issue which is often supported by an unwillingness by any one of these entities to find a middle ground. For the sake of all concerned, we need to find a way to compromise and work closer together in solving this multi-faceted problem.

Workforce Diversity

Question:

The state's physician workforce is losing ground in terms of its racial and ethnic diversity. Of California physicians who reported their race or ethnicity in 2000, African Americans and Hispanic/Latinos comprised less than 5% of the state's physicians although they made up about 7% and 31% of the state's population respectively. The medical education and training pipelines do not show significant advances in recent years in racial

and ethnic diversity.[3] Do you think cultural and language access could be better addressed if there were more African American, Latino and other culturally and linguistically competent physicians available?

Summary Response:
The respondents agreed that the problem of language access could be better addressed if the medical schools had more graduates of color to serve Limited English Proficient patients. With affirmative action and other such remedies being aggressively disbanded in California (Proposition 209), there was very little hope that this problem would get better unless the medical schools took aggressive efforts in recruiting, supporting and maintaining Latino and other minority students to the medical profession.

It was felt that preparing Latinos for a career in the health professions would take a long-term, concerted and multi-faceted approach. There needs to be a "pipeline," that begins with an emphasis on education from the earliest end of the educational system. Shamefully, the least funded, poorest performing schools have a large number of Latinos. Drop out rates are high and the support systems to keep young Latinos in school are not considered a priority in the educational system. Those who do well academically are not readily fostered, mentored or supported. Those in impoverished communities must struggle to remain in school. Their parents do not always know how or what resources exist to support the student who is left on their own to determine the best means of financial support.

The groups felt there had been considerable research completed to define the problem. However, they did not feel there was any concerted effort to solve or address this long standing issue. The issue is complex and there are many reasons why this is a continued problem. There was a universal feeling that no one wants to take this problem head on nor was there a will strong enough to insist that this problem be addressed. They felt the universities were not doing enough but did not feel there was a force strong enough from the Governor on down to push for change. This was thought to be a severe inequity for Latinos and a denial of just access and opportunity. Given that this problem is so wide-spread, and deeply rooted, respondents felt that Latinos would continue to be an educational underclass in the medical profession. More disturbing, was what they perceived to be a societal acceptance of this "norm."

[3] *The Practice of Medicine in California: A Profile of the Physician Workforce,"* California Workforce Initiative, Center for the Health Professions, University of California, San Francisco February 2001

Cultural Competency Standards and Enforcement at the State Level

Question:

There are no state adopted standards for interpreter services. How does this impact the patient and the providers of LEP services?

Summary Response

There was a consensus that standards need to be established for interpreters. Healthcare providers and organizations rely on people who speak another language that they themselves do not speak. Over the past several years a number new interpreters services have been established in communities. When a provider or health care organization contracts with such services they have no way of measuring the accuracy or proficiency of the interpreters. An interpreter may be able to translate the communications from patients but they may not be trained in medical terminology or even basic health practice measures so that they can effectively communicate more routine instructions or adequately receive information from patients that may be of value in treatment. By and large, most services have to be good to remain in service. However such services are overburdened and over booked.

There was concern that there are not enough bilingual staff to provide the level of services required for LEP clients. Reliance on language lines and interpreters is likely to continue for some time until the supply catches up with the demand. There was a strong perception that the governmental health programs like Medi-Cal and Healthy Families complete the very minimum of compliance tracking. They do not feel that there is a concerted effort to complete this task in any of the major health programs.

Medi-Cal Reimbursement

Question:

California's Medi-Cal rates were comparatively lower than 42 states, amounting to an average of 47 percent of the Medicare rates in 1998. How has that impacted providers and patients?

Summary Response

Several of the participants were able to identify one or more providers who had either retired, left medical practice or reluctantly began to refuse to serve Medi-Cal and even Healthy Families patients. The rate of reimbursement is so low that providers cannot recoup the cost of providing services, let alone make money on the program. When budget crisis or curtailments occur, this is one of the first programs proposed to to be cut. This is a major disservice to the most vulnerable populations. When you couple the low rate of reimbursement and the fact that there is no reimbursement for language access services, it will take a major effort to

provide the level of support needed. The patient is the loser in this process because the number of service sites providing language support services becomes even more limited.

Recommendations

There was a consensus that much more needs to be done to catch up to the growing need for language access services. The recommendations were drawn from the respondent's comments on each of the questions listed above. They are listed here in total rather than in each summary response section. There were some areas where the respondents did not have recommendations or the same recommendation would cover more than one issue, therefore they are listed in summary below:

- Recognize that the diversity of the state's population will continue to grow and proactively move to address their needs especially in the health care setting.
- Accept that providing language access services is a "part of doing business" if services are to be provided to LEP patients.
- Recognize that people will cling to their original language especially when they are in health care crisis or do not feel well.
- More research needs to be done on the level of negative impact or risk LEP patients are placed in when they seek care in facilities that do not offer language access services.
- A more aggressive, progressive and concerted effort needs to be made to ensure that Latinos and other people of color are provided access to the health professions. Medical, dental, nursing and other health professions universities and schools should be held accountable for their failure to provide access.
- Ensure that bilingual employees are compensated for providing language access services and that there workload is not increased unduly to provide services. Monitor the level of language access service required and augment bilingual staff services with interpreters, as need dictates.
- Establish standards for interpreters as a job classification and establish standards for clinical and medical terminology requirements. Examination and Certification standards should be established by the State Department of Health Services and should be enforced to ensure compliance.
- Establish cultural and language competency standards for providers at all levels to determine proficiency and provide timely, on-site training to improve skills where they are limited or lacking.
- Increase the rate of reimbursement overall for Medi-Cal and Healthy Families programs. The State Department of Health

Services should seek matching funds for language access services.

- The CLAS standards that exist should be defined for California and strictly enforced to ensure that language access services are provided in a culturally and linguistically competent manner.

LATINO COALITION FOR A HEALTHY CALIFORNIA

"Culturally and Linguistically Appropriate Services (CLAS) Standards - Points for Discussion."

The paper in the following pages was given to participants in advance of the focus group sessions. The paper draws no conclusions. It served as "points for discussion" during the focus group sessions

Culturally and Linguistically Appropriate Services (CLAS) Standards
"Points for Discussion."

"Every society recognizes its healers or health care providers as central to the functioning of the human civilization, but few previous societies have been as culturally diverse as ours, offering both a challenge and opportunity to those who would, as their chosen vocation, cure and comfort the afflicted."

Quality Health Care for Hispanics: The Cultural Competency Component
DHHS, HRSA, BPHC. OMH, SAMHSA

Introduction

The Latino Coalition for a Healthy California (LCHC) is the largest Latino health advocacy group in California and is known for producing groundbreaking reports on health issues. Since Latinos represent the largest portion of LEP population in California, it is reasoned that we would have an opinion. The LCHC is expected to have a position on the most recent federal guidelines on Culturally and Linguistically Appropriate Services (CLAS) Standards to meet the needs of Limited English Persons (LEP). Consistent with our interest in advocating an informed position, we have embarked on information gathering hosting analytical discussions in several venues. It is apparent that to meet the needs of all persons in California who require health services and speak or read limited English, thoughtful and productive implementation of the guidelines in California will require a concerted effort on several fronts.

The diversity of California's population and its language access needs places our state in the forefront of this challenge. The purpose of this document is to highlight information that will need to be considered as the discourse on this issue proceeds. This is not a position paper. It provides points of discussion to facilitate consensus building on this compelling issue. Primary among these points are the state's healthcare workforce, and two federally financed health programs in California that provide health access to a large proportion of people of color with language access needs. To provide context for this discussion information is also provided on:

- data on both the diversity of the population and the broad range of languages spoken in California as well as the implications for healthcare (or any industry in the state) are briefly reviewed;
- the state's enforcement of existing standards, preparedness for certifying and training interpreters, and a recent Legislative Analyst's Office report on Medi-Cal reimbursement rates and recent legislative action.

These are presented to give an, albeit limited, but telling, view of the state's ability to respond to these issues, and the response from mainstream physician associations to: (1) require the state to assume responsibility for interpreter services and (2) a request to place a moratorium on the most recent guidance on cultural and linguistic standards.

Implications for Health Access

The most compelling reason to take up this charge is the negative implications that denial of language access has on health access. A recent report included in Medical Care Research and Review indicates: "Analysis have linked language barriers or limited English proficiency (LEP) with fewer physician visits and reduced receipt of preventive services, even after controlling for such factors as literacy, health status, health insurance, regular source of care, and economic factors."[4]

Health care is the outcome of the interaction between the two fundamental processes – *access and utilization* – of health care services. An individual's ability to gain access to clinical diagnosis and treatment, coupled with that person's experience in the utilization of these gained services determines the quality of health care.[5] Although many factors affect health status, the lack of health insurance and other barriers [like limited English proficiency] to obtaining health services diminish racial and ethnic minorities' utilization of preventive services and medical treatments that could reduce disease and contribute to improved health status:

- Uninsured people with chronic health conditions visit health care providers less often than insured people with these conditions;
- Among people with chronic health conditions, the uninsured are far less likely than the insured to have an ongoing relationship with a health care provider.
- Uninsured people with chronic health conditions are much more likely than their insured counterparts to report that they or a family member did not receive a doctor's care or prescription medicines due to the need to pay for food, clothing or housing.[6]

Not only are clinical services compromised when a provider is unable to effectively communicate with a patient, but so are the patient's ability to find and obtain services, navigate through health care bureaucracies, and

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[4] *"Can Cultural Competency Reduce Racial and Ethnic Health Disparities?"* Medical Research and Review, Vol.57 Supplement 1, (2000) 181-217 © 2000 Sage Publications, Inc.

[5] *"Is There a Doctor in the Field? Underlying Conditions Affecting Access to Health Care for California Fammrworkers and Their Families,"* B.L. Bade, California Program on Access to Care, California Policy Research Center

[6] *"Getting Less Care: The Uninsured with Chronic Health Conditions,"* Families USA, California HealthCare Foundation, February, 2001.

comply with treatment regimens. For this reason, we must collectively find solutions that will address this compelling issue.

Background

On December 22, 2000 the Department of Health and Human Services (DHHS) Office of Minority Health (OMH) Culturally and Linguistically Appropriate Services (CLAS) Standards was issued to reaffirm and clarify that the CLAS standards are already legal requirements under Title VI. On January 19, 2001 the Department of Health and Human Services (DHHS), Health Care Financing Administration (HCFA) issued the Medicaid (Medi-Cal in California) Managed Care Final Regulations 66 Federal Register 6228 on linguistic and cultural competency. There are other state and federal guidelines that support these standards (See attached summary). The issuance of these two most recent notices have stirred discussion in California because the requirements are long-standing as part of Title VI. There is a need for standards. All who enter the dialogue must recognize the opportunities and challenges that are presented in meeting the needs of Limited English Persons (LEP) in a state where a majority of are people of color -- many being monolingual in their native language.

The Office of Civil Rights (OCR) Policy Guidance 65 Federal Register 52762 reaffirms application of Title VI to prohibit discrimination based on primary language. It requires recipients of federal funds to ensure "meaningful access" to health and social services for Limited English Proficient (LEP) individuals through language assistance. The Guidance lists four elements for fulfilling this requirement: assessment, development of a comprehensive written policy on language access, training of staff and vigilant monitoring. The guidance also states the LEP individuals should not be required to use family members or friends as interpreters (unless requested by the individual after being advised that a free interpreter is available).

The guidance also requires competency of interpreters. It describes "safe harbors" to ensure compliance that require translated written materials for LEP populations that are either 10% or 3,000 (whichever is lesser) of the total eligible population. It also requires translated written "vital documents," for LEP populations that are either 5% or 1,000 (whichever is lesser) of the total eligible population; and translated written notice of the right to receive competent oral translation or written materials for LEP populations with fewer than 100 persons.[7]

[7] "Federal Laws, Regulations and Policies on Linguistic Access," Asian and Pacific Islander American Health Forum, San Francisco February 20001

Diversity of the State

According to the 2000 Census California is one of the most racially and ethnically diverse states in the US: American Indian/Alaska Native .5%; Asian/Native Hawaiian and Other Pacific Islander 11.2%; Black/African American 6.4%; Latino 32.4%; Some Other Race 0.2%; Two or More Races 2.7%; and White 46.7%. No one race holds a majority; however, collectively, minority populations are now a majority in the state of California.[8]

California's population is undergoing dramatic racial and ethnic change as it evolves from a largely white state to one with a much more diverse population. In 2000, the US Bureau of the Census designated California a majority-minority state, as the proportion of the state's White population fell below 50 percent. The California Department of Finance estimates that by the Year 2020, half of the state's population will be Latino and Asian American. In 40 years, whites are expected to represent only one-third of the population, while Latinos, African Americans, and Asians will account for two in three California residents.[9]

It is projected that the diversity of the population in California will continue to grow. Over the thirty-year span from 1990 to 2020, the projections indicate that California's foreign-born population will increase by 5.5 million, or 83.8 percent, from 6.5 million to 12.0 million. Over the whole 30-year projection period, the foreign-born share of the state's population is projected to rise by only 4.6%, following a 6.8% jump between 1980 and 1990. Most of the increase occurred by the 2000 census and the foreign-born share of California's population is projected to stabilize at slightly over 26% after 2010.[10]

Language Diversity

California is the most linguistically diverse state in the nation, with more than 200 languages and innumerable dialects. No portion in the state more dramatically demonstrates the diversity of languages spoken than Southern California. There is very little data on the languages spoken in health care settings, however, a Los Angeles Times study on language in the Southern portion of the state school systems illustrates the wide span of languages in California with 120 now spoken in the region. In 1981, 139 schools had 10 or more languages spoken by students not fluent in

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[8] Source: US Census Bureau, Census 2000 redistricting Data (Public Law 94-171) Summary File, Matrices, PL1, PL2, PL3 and PL4.

[9] *Finding Common Ground: Race and Ethnic Attitudes in California,"* Public Policy Institute of California, San Francisco, CA 2001

[10] *Demographic Futures for California, Projections 1970 to 2020 that Include a Growing Immigrant Population with Changing Needs and Impacts,"* Population Dynamics Group, School of Policy, Planning and Development, University of Southern California, January 2001

English. By 1999, that number had grown more than fivefold, to 797 schools - - one in four in the five-county area. Languages spoken by 1,000 or more students in the five-county area of Southern California who are not proficient in English are: Spanish, Vietnamese, Korean, Armenian, Cantonese, Khmer (Cambodian), Mandarin, Tagalog (Philipino), Arabic, Japanese, Persian (Farsi), Russian, Thai, Lao and Urdu.[11]

MAJOR HEALTH PROGRAMS FINANCED BY FEDERAL DOLLARS

The two state healthcare access programs in California to be impacted by the federal guidance are Medi-Cal and the Healthy Families programs. Both programs serve the impoverished that are, for the most part, people of color who would most likely need language access services. Also of significance are the large number of uninsured and the connection between these two programs and those who do not have insurance.

Medi-Cal

Medi-Cal, the state's Medicaid program, has provided coverage for children (and their parent) in families with low incomes since 1965. The program is a federal-state partnership, which means both California and the federal government set rules and share in program costs. In addition, Medi-Cal is an entitlement; any child meeting eligibility requirements has a right to a specific set of benefits outlined in the law. Medi-Cal is the state's largest health insurance program covering 2.7 million children and 2.3 million other beneficiaries, including parents and pregnant women, disabled children and adults, elderly Medicare beneficiaries, and other special needs populations.

Healthy Families

Children in families with slightly higher incomes may be eligible for Healthy Families, California's State Children's health Insurance Program, which began in 1998. Healthy Families was created when the Balanced Budget Act of 1997, which made federal funding available to states to expand health insurance coverage of children. Healthy Families subsidizes the purchase of insurance coverage on children's behalf and requires families to pay a small premium and co-payments for physician visits. Like Medi-Cal, Healthy Families is a federal-state partnership, though its rules and structure allow the state more latitude in administration and service delivery than Medi-Cal and federal funding is capped at an annual allotment (The enacted 2000-2001 California Budget indicates the state will not close enrollment in Healthy Families if federal funding is depleted).

[11] Source: California Department of Education, Data analysis by D. Smith, Los Angeles Times January 23, 2000.

The Uninsured

Diverse populations represent the largest numbers of uninsured in California. The providers who care for the uninsured are often the same providers who serve the Medi-Cal population. These hospitals, clinics and physicians frequently use their income form the Medi-Cal program to subsidize uncompensated care. However, the advent of managed care and the flat growth rate of Medi-Cal rates are threatening providers' ability to cross-subsidize care for the uninsured. Therefore, Medi-Cal funding decisions impact not only California's 5 million Medi-Cal beneficiaries, but its uninsured population as well.[12] The ranks of the uninsured are growing: 40% Latino; 23% Black/African American; 22% Asian/Pacific Islander and 15% White.

Uninsured Children

- 3 in 10 are Latinos
- 1 in 10 are White
- 1 in 10 are Asian/Pacific Islanders
- 1 in 10 are African American

Children Eligible for MediCal & Healthy Families

- 3 in 5 are Latino
- 1 in 5 are White
- 1 in 10 are Asian/Pacific Islanders
- Less than 1 in 10 are African American

Family Status

- 4 in 5 live in working Families
- More than 2 in 5 live below poverty
- Nearly 9 in 10 live in families with incomes below 300% of poverty
- Nearly 1 in 5 are immigrant children
- 3 in 10 are citizen children with immigrant parents

Where They Live

- More than 2 in 5 live in Los Angeles
- 3 in 10 live in Southern California
- Nearly 1 in 10 live in Northern California
- 1 in 10 live in the Greater Bay Area
- Nearly 1 in 10 live in the Central Valley

Workforce Diversity[13] [14]

In an ideal world, the healthcare workforce would be as diverse as the population served. In California, it is not. The issue long-standing and compounds the problem of language access even further because health

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[12] *Why are Medi-Cal Rates Important?"* Medi-Cal Policy Institute, Medi-Cal Issues, Number 1, May 1999

[13] California Workforce Initiative, UCSF Center for the Health Professions, San Francisco, CA www.futurehealth.ucsf.edu

[14] "*HRSA State Health Workforce Profiles,"* Bureau of Health Professions, National Center for Health Workforce Information and Analysis, US Department of Health and Human Services, Rockville, MD

care professionals are, by and large, not language and culturally proficient at a level to meet the needs of California's diverse population.

Physicians

Recent studies have documented a 43% decrease (since 1993) in Latino and other underrepresented minority enrollment at University of California medical schools exacerbating an existing shortage of Latino physicians. In fact, nearly 40 percent of Latinos from California who ultimately attend medical school, must do so out-of-state. Study of a recent cohort of native-born, US-trained Latino medical school graduates shows that 93% of those practicing in the state attended medical school and/or received their medical residency training in California. This demonstrates a direct relationship between medical education opportunities in the state and foreshadows the negative impact current policies that limit the supply of Latino and other minority physicians will have in the future.

However, the limited number and competitive nature of medical schools and recent changes in affirmative action policies in the public sector, have made it increasingly difficult for Latinos to gain admittance. In 1998, there had been a 25% reduction in minority applicants; a 30% reduction in minority admissions and a 32% reduction in minority matriculants to UC and private California medical schools. At the same time, California's private medical schools, Stanford and Loma Linda University, have also experienced diminishing Latino enrollment, leaving some to speculate that prestige and scholarships have lured many Latino candidates to medical schools outside of California.[15]

Strategies that focus on health professional training must be seen as long-term investments. The training "pipeline" for a physician can be 11 to 14 years, assuming that students are appropriately prepared at the high school level to begin and complete undergraduate and pre-medical training. There is significant attrition that occurs along this pipeline. Of the estimated 3,000 underrepresented minority college freshmen who indicate an interest in becoming a physician, only 500 eventually apply to medical school and 250 are accepted – an attrition or "drop-out" rate of 82 percent.

The state's physician workforce is losing ground in terms of its racial and ethnic diversity. Of California physicians who reported their race or ethnicity in 2000, African Americans and Hispanic/Latinos comprised less than 5% of the state's physicians although they made up about 7% and 31% of the state's population respectively. The medical education and

[15] *Underrepresented Minorities and Medical Education in California,"* A Report by the Center for California Health Workforce Studies UC San Francisco, March 1999

training pipelines do not show significant advances in recent years in racial and ethnic diversity.[16]

Dentistry

There are 22,720 active dentists in California. Latinos and African Americans are underrepresented based on their percentage of the population. In1996-97 in 50% of California dental school graduates, 69% of dental hygienists graduates and 43% of dental assistant graduates were White. Thirty seven percent of dental assistant graduates were Latino.

Nurses

In 1996, the RNs employed in nursing in California we 83.5% White; 3.5% Latino; 5.0% Black/African American and 8.0% were Asian/Pacific Islander. In 1996-97, 60.3% of the RN degree recipients in California were White and 19% were Asian/Pacific Islander. Approximately 13% were Latino; and approximately 7% were Black/African American.

CULTURAL COMPETENCY STANDARDS and ENFORCEMENT AT THE STATE LEVEL

In the Spring of 1999 the State Office of Multicultural Health surveyed DHS branches and programs to assess strengths, weaknesses, and attitudes toward cultural competency. Approximately 88 percent of program personnel responded to the survey, which looked at disparities in health status, access to service, linguistic resources, community input, cultural beliefs and practices, outreach, and program resources. Most programs reported a lack of useful information on the cultural and attitudes of the multiple ethnic groups living in California. However, this problem is not unique to California. A similar study by Oregon's Office of Minority Health searched a large number of databases and reviewed over 100 journals, half of which were specific to health care issues with little success in finding guidelines on cultural and linguistic competence.[17]

The Medi-Cal Managed Care Policy letter on Linguistic Services requires health plans to develop and implement specific policies for ensuring, competent, 24-hour-a-day interpreter services for plan members with limited English proficiency, but enforcement rarely occurred while under the auspices of the Department of Health Services. The specific language *encourages* institutions under contract to comply. Last year, the State created a Department of Managed Care. To date, the new Department

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[16] *The Practice of Medicine in California: A Profile of the Physician Workforce,"* California Workforce Initiative, Center for the Health Professions, University of California, San Francisco February 2001

[17] *"Closing the Gap, Supporting State Offices of Minority Health,"* Office of Minority Health, Office of Public Health and Science, US Department of Health and Human Services, September/October 2000

has taken up development of policies and standards as a part of a legislatively mandated consumer "report card." With a standard for enforcement the "encourages" compliance and a Departmental understanding of the cultural and linguistic needs of diverse populations limited, it is unlikely that enforcement of CLAS Standards will move up in priority without motivation.

Standards for Interpretors/Language Services

A MMCD Policy Letter was issued to provide clarification regarding Medi-Cal managed care plans contract responsibility in providing quality translation of written materials to members who have limited English proficiency and speak one of the languages which meet the threshold and concentration standards. It also provides recommended guidelines on what constitutes a quality translation process for plan-developed informing materials. While the state and federal requirements indicate use of proficient interpreters, no state agency provides certification for medical translation. The California Healthcare Interpreters Association (CHIA) is trying to develop a standardized test, with a first draft to be issued in April 2001 (Spanish only). Other languages will follow.

Medi-Cal Reimbursement

In February, 2001, the Legislative Analyst's Office (a non-partisan office which provides fiscal and policy information and advice to the Legislature) issued a report on Medi-Cal Physician Rates.[18] The findings indicate that rates paid to physicians for services provided under the Medi-Cal Program are relatively low compared to rates paid by the Medicare Program and other health care purchasers. Medi-Cal rates for certain medical services were often less than half the rates paid by other health purchasers. The LAO cites a national study of physician rates in state Medicaid programs by the Urban Institute which found that California's rates were comparatively lower, amounting to an average of 47 percent of the Medicare rates in 1998. The LAO Report further indicates DHS has not conducted annual rate reviews or made periodic adjustments to Medi-Cal rates to ensure reasonable access to health care services.

Legislative Action

Assembly Bill 2394 Firebaugh establishes a Task Force on Culturally and Linguistically Competent Physicians to develop recommendations for continuing education program that includes language proficiency standards of a foreign language to meet linguistic competency and the key cultural elements necessary to meet cultural competency. The Task Force must report to the Legislature within two (2) years. A subcommittee

[18] *"A More Rational Approach to Setting Medi-Cal Physician Rates,"* Legislative Analyst's Office, February, 2001 www.lao.ca.gov

of the Task Force will study the feasibility of establishing a pilot program that would allow Mexican and Caribbean licensed physicians and dentists to practice in nonprofit community health centers in California's medically underserved communities. Currently, about 20 percent of California's practicing physicians were trained in countries other than the U.S., and 13 percent of those receiving medical residency training in the state went to foreign medical schools. However, in 1999, only 14 percent of those foreign medical school graduates in California medical residency programs had attended a medical school in a Latin American country. The Task Force met for the first time on March 8, 2001 in Sacramento.

Reaction to Clas and LEP Standards

In January 2001, the Southern California Physician, the Official Magazine of the Imperial County Medical Society, Los Angeles County Medical Association, Orange County Medical Association, Riverside County Medical Association, San Bernardino County Medical Society and the Ventura County Medical Association published an article, "Talk Isn't Cheap, Does Your Practice Comply With Laws Regarding Interpreter Access?" It stirred reaction from physician groups and advocates alike. The California Medical Association has formally asked the Department of Health Services to fund interpreter services or create a statewide interpreter pool. It is recommended that interpreters bill the department for services and be paid by the Department.

More recently, the Academy of General Dentistry, American Academy of Dermatology Association, American Academy of Family Physicians, American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Neurology, American Academy of Ophthalmology, American Academy of Oral and Maxillofacial Radiology and the American Academy of Otolaryngic Allergy, have issued a letter to Tommy Thompson, newly appointed Secretary, DHHS. The letter requests that an immediate moratorium be placed on the OCR Guidance. The major resistance by the medical community has been addressed as an issue of reimbursement for services rendered under the Medi-Cal and other state/federal programs. Not one ethnic specific medical group signed the letter.

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LATINO COALITION FOR A HEALTHY CALIFORNIA

Programs Designed for Limited English Proficient Populations

Background

Having heard from the focus groups it was important to determine what programs did exist for Limited English Proficient (LEP) populations in the private sector, public and community health settings. The following is a sample of the types of programs that exist in California. This is not a compendium of services. While the programs included are exceptional, there are many "best practices" that exist in California that are just as worthy of being featured. The intent was to show samples of the "types" of services available in private, public and community health care settings. The programs listed indicate that much is being done in each of these sectors. Certainly, much more needs to be done, but this small sampling indicates that there is a commitment to continue to improve services for LEP clients.

Each of the programs featured submitted their statement of services. The narratives are unedited to provide a broader spectrum and scope as presented by the participating programs. In addition, the programs are so varied, I was hard pressed to find a "cookie cutter" format that would they could fit into. I am truly grateful to all of the health plans and associations who took the time to submit information. Their continued efforts on behalf of LEP Latinos and other populations of color are to be commended.

HEALTH PLANS
– NOT-FOR-PROFIT

Alameda Alliance for Health

Description of Organization

In 1993 the State of California unveiled a plan for moving most Medi-Cal (Medicaid) beneficiaries from the "fee-for-service" health care delivery system to a system of managed care. The State developed a service delivery model that includes locally developed and operated health plans to serve eligible Medi-Cal beneficiaries. These local plans are innovative partnerships among county health care services, safety net and traditional Medi-Cal providers, private sector providers and the local communities. Today, eight such "Local Health Plans" serve Medi-Cal beneficiaries in 12 of 58 counties throughout California.

Alameda Alliance for Health (the "Alliance") is a public health plan that offers locally based health care services to low-income residents of Alameda County, California. Since it began operations in 1996, the Alliance has been strongly committed to providing comprehensive, high quality, accessible health care to its culturally and linguistically diverse membership, comprised of traditionally underserved children and adults throughout Alameda County. Nearly three-quarters (73%) of the county's Medi-Cal managed care-eligible patients are Alliance enrollees, as are 57% of the County's Healthy Families (SCHIP) enrollees.

The Alliance evaluates, implements, and integrates cultural and linguistic competency throughout plan operations in order to create a culturally competent organization, increase access to care, enhance quality of care and health outcomes, maximize patient satisfaction and retention, and reduce health disparities.

Provider Network

The Alliance serves its membership through a provider network of more than 1,300 physicians practicing in solo and group practices and in community clinics, over 100 ancillary providers, 160 pharmacists, and all major hospitals in the county. In addition, many private and group practices, as well as many community clinics have made providing health care to the major cultural and linguistic groups in the county a priority, including La Clínica de la Raza, Tiburcio Vasquez Health Center, Asian

Health Services, Native American Health Center, and West Oakland Health Center (African American focus).

Seventy-five percent of the network of contracted Alliance provider locations report an in-office ability to serve patients in at least one language other than English, for a total of 20 different languages. Provider language capacity is documented in the Provider Directory.

Alameda County

Alameda County is an area of 820 square miles (land and water area), over 50 miles across, comprised of 16 cities, with an estimated 1,375,850 residents. The largest city is Oakland, with an estimated total population of nearly 390,000.

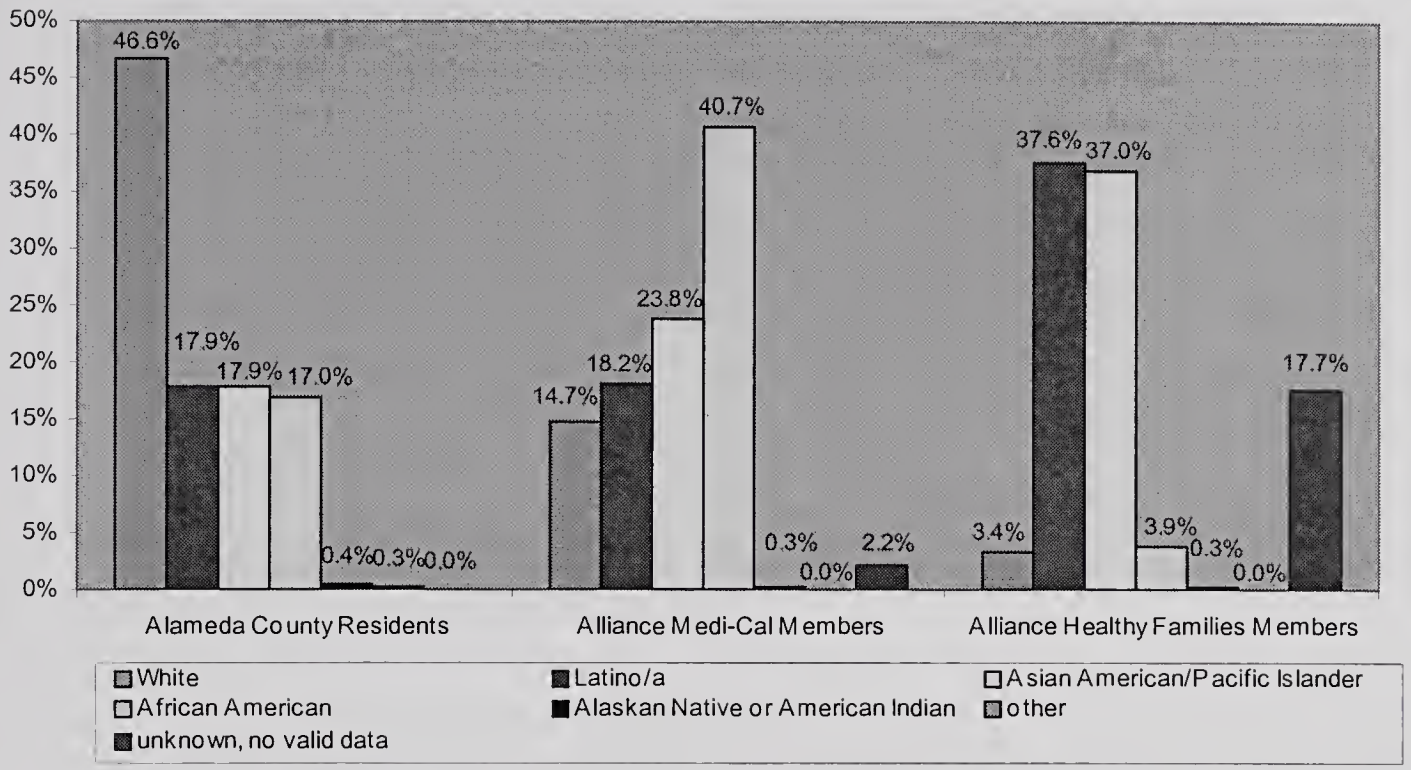
Description of Total Population Served In California

Alameda County is one of the most racially and ethnically diverse counties in the country. Over the past decade, Alameda County's White population has declined and the Latino/a and Asian/Pacific Islander populations have increased as a proportion of total population. The African American, Native American and "Other" groups have remained stable. According to Census 2000, 273,741 Latinos/as lived in Alameda County, accounting for 19% of the total population. This represents a 50.7% growth from the 181,805 Latinos/as living in Alameda County in 1990. More specifically, there was a 79% growth in the number of Latinos/as in Hayward, 69% in Oakland, 54% in San Leandro, and 40% in Newark.

Alliance demographics indicate that 87% of our members are people of color (of over 85,000 current plan members, 31% are African-American, 26% Latino/a, 13% White, 9% Vietnamese, 6% Chinese, 2% Cambodian, 1% Laotian, and 8% other Asian/Pacific Islander), with over 45% who have a primary language other than English (the largest groups being 20% Spanish, 7% Vietnamese, and 7% Cantonese).

As the chart below indicates, the demographics of the Alliance's membership is quite different from that of the County as a whole. Alameda Alliance for Health has a significantly larger African American population and significantly fewer Whites. A full 87% of Alliance members are in racial/ethnic groups other than White, indicating the need for the Alliance to continuously examine and proactively address cultural and linguistic issues throughout the Alliance.

Racial Composition of Alameda County vs. Alameda Alliance for Health



Membership

In addition, a higher percentage of the Alliance's total membership (45%) speaks a language other than English. This compares to 24.8% of all Alameda County residents who speaks a language other than English at home (1990 Census data).

Program(S) Designed to Serve Latinos/as and Other People of Color

As part of the Alliance's commitment to serve a diverse community, the Alliance has actively designed organizational-wide and program-specific cultural and linguistic infrastructures to best meet the needs of our diverse community. Towards this end, the Alliance created a Cultural and Linguistic (C&L) Program with full-time dedicated staff. The C&L Program develops strategies and provides guidance in the implementation of culturally and linguistically appropriate health care services. In addition to its ongoing C&L operations, its functions include an organizational assessment, Cultural Competency Initiative, and Linguistic Competency Initiative. Ongoing operations include translation of member materials; payment for qualified medical interpreter services; payment to providers for the use of qualified medical interpreters; training for providers and Alliance staff; and an internal consulting services to integrate and support C&L efforts across all departments.

Internal Assessment and C&L Program Development

The C&L Program conducts ongoing organization-wide assessments of cultural and linguistic related activities and integrates cultural and linguistic competence-related measures into internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations. Integrating cultural and linguistic competency-related measures into existing internal audits and quality improvement activities helps to institutionalize a focus on cultural and linguistic competencies within the Alliance. By linking the organizational assessment processes to quality and outcome efforts, this integration has the additional benefit of helping to build the evidence base regarding the impact of cultural and linguistic interventions on access, patient satisfaction, quality, and clinical outcomes (US DHHS, OMH, October 2000).

In keeping with the Office of Minority Health guidance, major domains for assessment include the following:

- Governance of organization
- Plans and policies in support of cultural and linguistic programming
- Patient care
- Quality monitoring and improvement
- Management Information Systems
- Staffing patterns
- Staff and provider training and development
- Communication and linguistic support

In order to implement the C&L strategic plan, an infrastructure has been created to provide the necessary resources. These resources include organizational commitment, programmatic and agency-wide policies and procedures, program budget, dedicated staff, and in-house and contracted expertise.

Cultural Competency and Language Proficiency Initiatives

One of the Alliance's top priorities is the implementation of clear standards and useful measures to enable plan and providers to better assess performance in the key area of cultural competency and language proficiency. They intend to measurably improve provider skills regarding culturally competent health services, and go beyond cultural "sensitivity" and changing value systems. Instead, the Alliance is implementing a new model for knowledge and skills building through training and measurement. The Alliance's goal is to increase member satisfaction and ultimately to reduce the extent of health disparities.

The" Cultural Competency Initiative" is a two-year feasibility study funded by The California Endowment to establish the business case for cultural competency training and assessment of health practitioners in a managed care setting. This study examines quality of health care, with a focus on processes of care (e.g. access, preventive care, satisfaction, and trust), as well as selected health indicators. The Alliance is the first managed care organization to implement a newly scientifically validated tool that assesses level of cultural competency among medical providers, based on a model of a continuum of culturally competent care. This continuum has a vertical axis composed of three areas of competency and a horizontal axis specifying the four levels of cultural competency. Results of this two-year project will inform the Alliance and other health plans of how to institutionalize a systemic approach to providing culturally and linguistically appropriate health care services.

The *Feasibility Study of Implementing Cultural Competency Assessment and Training of Providers in a Managed Care Organization* examines the feasibility and effectiveness of implementing cultural competency assessment and training of providers as part of a systems approach to dealing with culturally competent health care in a managed care setting. The purpose is to develop a business case for an institutionalized, ongoing cultural competency assessment and training program with related ongoing quality improvement initiatives. Specifically, the goals of this study are to:

- conduct *assessments* of health care providers cultural competency through an ongoing feedback loop;
- provide cultural competency *training* based on cultural competencies mirrored in the assessment tools;
- examine whether assessment and/or training of practitioners *increases level of cultural competency*;
- examine whether level of cultural competency is related to *processes and outcomes of care*;
- examine business related consideration in the effective implementation of assessment and training (e.g. type of health care setting, method of delivering assessment and training, provider compensation, collection and management of data); and
- *institutionalize* an ongoing cultural competency assessment and training program with related ongoing quality evaluation.

This study uses scientific methodology, as well a business model of organizational analysis. This is a randomized control treatment study examining the effect of assessment alone v. assessment plus training on increasing level of cultural competency among providers, and the effect of cultural competency on quality of health care. The business model relies

on systems management and the organizational effectiveness evaluation (OEE) model. This model focuses on a coordinated chain of means-ends connections and the use of standardized numerical measures in determining effectiveness and cost efficiency. In this process, managers seek to identify which business activity contributes most to achieving the desired outcome of the organization.

The "Language Proficiency Initiative" is an eighteen-month study to identify and address gaps in quality health care services for limited English proficient (LEP) populations, with a focus on standards and assessment of language proficiency of providers in managed care organizations. This will address two major gaps identified in the current literature – 1) a focus on provider language skills (to date, the focus has been on patients and interpreters); and 2) a need for standards and means of assessment of provider language proficiency. *Provider* language proficiency has been the forgotten variable of the language access equation. Limited English proficiency (LEP) does not necessarily result in a patient not being able to communicate directly with the provider. Many providers rely on their own bilingual skills or those of their office or clinical staff.

The need to establish standards and measures for assessment of professional medical interpreters has recently been recognized. However, because the highest standard is direct patient-provider communication, it is critical to assess providers' language abilities before healthcare can move forward in examining the provider's role in the delivery of quality health care services for LEP populations. Results of this project will help to increase understanding of the importance and nature of the current gaps of provider language proficiency, to add more dimensions to understanding language concordance, to provide a report on beginning steps in managed care organizations to address these gaps, to make recommendations for future activities and research, and to discuss policy implications. The California Endowment funds this Alliance/Kaiser collaboration.

The Cervical Cancer Screening Study (PI Ninez Ponce, Ph.D., UCLA Center for Health Research Policy) examines how a language/gender/ethnic match between a patient and her physician would affect the likelihood of the physician making a referral for a pap test and the patient taking the test. The study focuses on adult female Medi-Cal members of the Alliance 1999-2000 and measures the performance of institutional and clinical providers of care with respect to limited English proficient (LEP) women's likelihood of getting a pap test in comparison to non-LEP women. The study team will analyze Medi-Cal encounter/claims data for fee-for-service and the CPT codes for pap tests for the managed care beneficiaries.

This project will answer several important questions, such as: (1) Is the presence of minority ethnic staff related to reduced disparities in cervical cancer screening? (2) Which subgroups benefit the most from an encounter with a physician who speaks the same language? (3) Which subgroups benefit the most from an encounter with a physician from the same ethnic group? (4) Does the benefit of language and/or ethnic match depend on whether the physician is a man or woman? And does this vary by ethnic group?

The Alliance was selected to be the only ***national managed care organization pilot site*** to model the implementation of ***Culturally and Linguistically Appropriate Services (CLAS) in Health Care*** standards recently released by the U.S. Department of Health and Human Services, Office of Minority Health (Federal Register, December 22, 2000, 65, 247, 80865-80879). As the U.S. population becomes more diverse, health care organizations and providers are interacting more often with patients/consumers from many different cultural and linguistic backgrounds. The development of appropriate organizational and system wide approaches to better serve the health care needs of diverse populations is becoming more paramount to the health care industry. Furthermore, managed care organizations are increasing their market share in serving low-income and diverse patients.

This paradigm shift makes it imperative that managed care organizations respond appropriately to the health care needs and preferences of culturally and linguistically diverse patients. The Office of Minority Health developed nationally recommended standards for culturally and linguistically appropriate services (CLAS) to assist health care organizations in providing care to racially and ethnically diverse communities. The provision of culturally and linguistically appropriate services to diverse patients has the potential to improve access to health care, quality of care, and health outcomes and to ultimately reduce health disparities.

The CLAS standards are currently being implemented as a national pilot project, funded by the Office of Minority Health, U.S. Department of Health and Human Services, at the Alliance. This study will contribute to the evidence base regarding the impact of the CLAS standards on organizational, provider, and patient behavior and help clarify concerns related to their costs and benefits.

Cultural and Linguistic Needs Assessments

Cultural and Linguistic Needs Assessments are conducted for the purposes of developing and implementing effective services, and to address the following elements: health related behaviors and practices; risks for disease, health problems, and conditions; knowledge, attitudes, beliefs, and practices related to access and use of preventive care; knowledge, attitudes, beliefs, and practices related to health risks; perceived health, health care, and health education needs and expectations; cultural beliefs and practices to alternative medicine; language needs and literacy levels; community resources and capability to provide health education and cultural and linguistic services; and the adequacy of the Alliance's provider network.

A key source of information for the C&L Needs Assessments are member surveys. The goals of these membership surveys are to investigate the opinions of members in the Alliance membership regarding their cultural and linguistic perspectives on health beliefs, access, and needs. Issues addressed access to health care providers, availability of health information, satisfaction of health care received, availability of written and verbal communication in members' primary languages, as well as demographic information such as education level, literacy level, bi-lingualism, and acculturation. Randomly selected members were interviewed by phone, representing the major ethnic and language groups of the Alliance membership. The surveys are conducted in the threshold languages of English, Spanish, Cantonese, and Vietnamese.

Culturally and Linguistically Appropriate Community Resources

As noted in the previous section, the Alliance's contracted provider network is extremely diverse in the cultural groups that they serve and the languages that are spoken. In addition, to the provider network, the Marketing and Communications, Clinical Services, and Member Services Departments also rely on a variety of community resources that often specialize in working with various cultural and linguistic groups.

Marketing/Outreach

The Marketing and Communications Department has developed extensive relationships with a variety of organizations within Alameda County in order to inform the uninsured about their opportunities to receive health insurance. These organizations include neighborhood centers, churches, schools, social service agencies, regional centers, county health projects, community health clinics, and community centers, most of which focus on serving underserved communities of color.

CLINICAL SERVICES

The goal of the Clinical Services Department is to enable members to make well-informed health care decisions and achieve overall wellness. This is accomplished through member and provider focused services and in partnership with diverse community and public agencies. The following three programs within the Clinical Services Department actively contribute towards improving the health outcomes and eliminating health disparities of Alliance members.

1. Health Programs (including both Case Management and Health Promotion)

Case Management identifies members who are high risk for poor health outcomes and coordinates with the member and the primary care provider to develop an individualized care plan. Case Management primarily focuses on asthma, diabetes and perinatal services. A multidisciplinary team assesses members' needs, including language, culture and family support, in order to identify the interventions, which will have the most impact. Particular effort is made to assure that members are able to receive educational and counseling services from a provider and within a culturally appropriate setting. Collaborative relationships have been developed with several community based programs to provide support services (e.g. case management, home visitation, substance abuse treatment) as part of this effort, with special attention paid to developing capacity within the African American, Latino, Chinese and Vietnamese communities.

Health Promotion primarily focuses on three areas: material development, acquisition and distribution; education classes for members; and community coalition building. Efforts to assure access to written, audio and visual health information is focused on assuring appropriate literacy level, language and cultural competency. All materials are made available in, at a minimum, English, Spanish, Vietnamese and Chinese. Educational classes are generally made available through agreements with community organizations and institutions.

This assures language, cultural and geographic access. Interpreter services are arranged when a class is not available in the member's primary language. Special staff and material support has been provided to the clinics represented through the Community Health Center Network to enhance their ability to offer a wider range of classes to their constituent populations. Health Promotion staff are also actively involved in community coalitions which focus on improving health outcomes for specific ethnic populations and within specific neighborhoods.

2. The Quality Improvement Program analyzes plan utilization data to assess the quality of and access to care for the Alliance membership. Specific attention is paid to analyzing health services utilization and health outcomes data by ethnicity and language in order to identify disparities and areas for improvement within specific sub-populations of the plan. Plan data is also compared to local, statewide and national data sets in order to have benchmarks against which Alliance outcomes can be compared.

3. Utilization Management (UM) facilitates access to specialty services and manages authorizations that are required for a limited set of services, including in-patient care, ancillary services and durable medical equipment. UM also analyzes utilization data to identify any over or underutilization of specialty services, including by specific ethnic and language groups.

Member Services

Member Services has a list of community resources available to provide to members as needed, which addresses many of the Alliance's membership's cultural and linguistic needs, including immigration advocates, such as Spanish Speaking Citizens Foundation and Asian Law Caucus. Phone numbers are listed by language when such services exist within the County.

National and Local C&L Discussions

The Alliance participates in national and local C&L discussions to inform and be informed in policies, practices and knowledge relevant to culturally and linguistically appropriate services in health care. For example, California Health Interview Survey: 1) advisory board member, 2) Adult Questionnaire Technical Assistance Committee member, and 3) Multicultural Technical Assistance Committee Co-Chair
California Task Force of Culturally Competent Physicians and Dentists: member

Collaboration with various universities and community organizations, such as UCSF, UCLA, CHIA, and NCIHC.

Advisory Groups and Technical Expert Panels, such as 1) Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile, prepared for HRSA, by The Lewin Group, Inc.; 2) Developing a Research Agenda for Cultural Competence in Health Care; supported by the DHHS, OMH, AHRQ.

C&L Work Group of Local and County Health Plans in California

Member invited conferences and convening presentations on topics such as health care for immigrants, and culturally and linguistically appropriate services in health care.

SPECIAL PROGRAMS FOR THE UNINSURED

Alliance Family Care and First Care

The Alliance is unique among health plans in its commitment to providing culturally and linguistically appropriate health care services. For example, the Alliance initiated an expansion of our services beyond those covered by Medi-Cal Managed Care and Healthy Families. In line with their mission to serve uninsured children and adults, they have launched two new programs for working families:

Alliance Family Care and Alliance First Care. The Alliance has committed $14.8 million, along with a generous grants from the California Healthcare Foundation and The California Endowment, to subsidize the cost of coverage for Alliance Family Care, which offers comprehensive medical and dental benefits to working, uninsured, and immigrant families whose household income is under 300% of federal poverty guidelines with no US citizenship or legal residency requirements. The Alliance First Care program has similar benefits and is open to people in any income range, with enrollees paying their own premiums designed to cover the full cost of their care. These initiatives extend our services to formerly uninsured people who historically have had little or no access to comprehensive medical and dental care.

Latinas in Alameda County Survey

In order to inform the Alliance's efforts on how to better provide health care coverage to the uninsured in Alameda County, the Alliance's Marketing and Communications Department conducted a survey (March 4-8, 2001) among uninsured Latinas in Alameda County to learn more about their understanding of health care coverage, familiarity with health plans, and sources and methods of receiving information regarding health care coverage. This is the first phase of a three-phase research project including focus groups and a follow-up survey.

The survey reached a total of 300 Latinas aged 18-49 in Alameda County who listen to Spanish-language radio and reported that one or more members of their household lacked health care coverage. Respondents to the survey were included without regard to citizenship status. Telephone numbers for the sample were drawn from a random digit dial

(RDD) sample targeted to concentrations of Latino/a surnames. The margin of sampling error is +/- 5.7%.

The Alliance's survey of Latinas in Alameda County revealed that uninsured women are mostly low-income. Over two thirds (70%) of those who responded to the question on household income make less than $20,000 a year, and almost half (44%) make less than $15,000. Still, four out of five (79%) either have a job or a spouse with a job, or both. Education levels are also low, with a slim majority (56%) having graduated high school. Over two-thirds of these women (71%) are married or living with a partner, while one in five are single (21%) and the rest divorced or widowed (7%). Four out of five (80%) have children, including 86% of those who are married and 67% of those who are single. About one third (31%) have three or more children at home.

Most of the respondents (63%) live in households that are mixed in their health insurance status – that is, some family members have insurance and other do not. Thirty-seven percent have no insurance for anyone in the household; these respondents also have among the lowest educational levels and lowest household incomes. Seven in ten respondents (71%) do not have insurance for themselves. Among those who are married, half (50%) of the husbands lack insurance; among those with children, 43% of the children lack insurance. Families with nobody insured – who are more likely to be non-citizens and undocumented – are less aware that affordable health care coverage of any kind is available to them.

Overall, just under half of the respondents (47%) believe that good quality, affordable health insurance is available to them. Non-citizens (53% of the sample) are distinct in their low awareness that health insurance is available to them. They would need to be convinced that they could get information in Spanish for free, that the process is simple, and that the cost of coverage is low. However, non-citizens are also the most likely to choose Alameda Alliance *for* Health first, perhaps due to good word of mouth in the community.

County of Alameda Uninsured Survey (CAUS)

The Alliance funded the UCLA Center for Health Policy Research $50,000 to conduct CAUS, which, for the first time, created a population-based surveillance system of the County's uninsured population. The results of this survey describe the County's uninsured populations by race/ethnicity, nativity and age. It was conducted in all the plan's threshold languages. The goals were to:

- Understand who are the uninsured, why they are uninsured, and for how long;
- Understand the financial, health and social impact of being uninsured;
- Understand the factors affecting enrollment and dis-enrollment in safety net programs, specifically the transition in and out of Medi-Cal and Health Families;
- Gain information for the design and implementation of insurance products including marketing, enrollment, dis-enrollment and access and network issues which affect participation;
- Determine access to and utilization of health services.

Results of this study can be found in the summary report by, Ponce et al *Advancing Universal Health Insurance Coverage in Alameda County: Results of the County of Alameda Uninsured Survey*. 2001. UCLA Center of Health Policy Research www.healthpolicy.ucla.edu. Community Voices Project – Oakland. www.communityvoices.org/ll-Oakland.asp.

SPECIAL PUBLICATIONS FOR LATINOS/AS AND OTHER PEOPLE OF COLOR AND THE LANGUAGES FEATURED

Written materials for Alliance members are reviewed for cultural appropriateness and are translated into threshold languages of Spanish, Chinese and Vietnamese by professional translation services. Written materials are printed in similar quality (e.g., paper stock, color and binding) for all languages, and distributed to the Alliance membership based on the primary language of each member. Whenever practicable, materials are printed in a multilingual or bilingual format.

The Alliance web site at www.alamedaalliance.com is a fully multilingual site, with all text available in English, Spanish, Chinese and Vietnamese.

Through its member newsletter, Alliance Alert, written by Alliance staff and produced quarterly, the Alliance tailors articles to the current and specific needs and interests of our diverse membership – 80% of which are immigrant and/or people of color.

Language Access Services

From the Census 2000, Supplemental Survey, 37% of Alameda County Latinos/as reported speaking English less than "very well". These would be defined as a limited English proficient (LEP) population who would require interpretation services as part of the overall mechanism for quality in healthcare delivery. Census 2000 recognizes that its methodology would undercount minorities, migrants, and populations of limited English

proficiency, and therefore the 37% is a conservative estimate of LEP prevalence among Latinos/as in Alameda County.

To date, the discussion of linguistically appropriate services has tended to focus primarily on patients and interpreters. However, many times patients and providers will speak, or attempt to speak, in the patients' non-English language. Many providers rely on their own bilingual skills or those of their office staff. The need to establish standards and measures for assessment of professional medical interpreters has recently been recognized.

However, as the gold standard is direct patient-provider communication, it is critical to be able to assess providers' language abilities before the field can move forward in examining providers' role in the delivery of quality health care services for LEP populations. Towards this end, the Alliance has designed and begun to implement a self-report language proficiency survey to providers to determine which providers and their staff speak what language and to what degree.

With funding from The California Endowment, the Alliance and Kaiser Permanente are working with experts on how to identify/develop (a) standards of language proficiency and (b) objective means to assess language proficiency. What is necessary organizationally and professionally to institute language proficiency standards and assessment? What are the barriers and motivations for a provider or an organization to participate with such an assessment? How can changes be made systematically?

Activities

The following are highlights of the current activities, future plans and long-term activities of the Alameda Alliance for Health in the area of language access and health care services.

The Alliance pays for the cost of qualified health interpreters directly to the interpreters, thereby relieving providers of further billing and reimbursement. The Alliance makes the arrangements for the attendance of such interpreters at medical and non-medical points of contact upon notification from the provider's (physician's) office of the upcoming need. The Alliance also recognizes with a separate payment the additional time and skills required by a provider when using a qualified health interpreter.

If a face-to-face interpretation cannot be arranged due to late notice or the unavailability of a qualified health interpreter, the Alliance pays for the cost of the use of telephonic interpreter services. The Alliance also makes an additional payment to a provider who uses a telephonic interpreter. The

Alliance regularly notices its providers of the availability of both qualified face-to-face and telephonic interpreters at no cost to the member patient. The Alliance specifically encourages its providers to use these resources while discouraging the use of family or friends and particularly minors, except in extraordinary circumstances.

The Alliance translates written materials directed to members in threshold languages. This is an ongoing effort to (a) ensure accuracy, completeness and cultural appropriateness; and (b) coordinate the translated materials with the goals and external approvals of their English counter-parts.

The Alliance is currently developing measurement tools to assess the language proficiency of both health interpreters and providers. We view this as a short and long term process. Besides our efforts in this development, we actively support such efforts by external parties to create a uniform industry standard.

The Alliance is specifically interested in developing measures and testing tools to ensure the language proficiency physicians and their office staff. Although oftentimes emphasis is placed on the role of health interpreters, many times communication continues between providers and LEP patients who don't share a common language without the use of health interpreters. While the Alliance is statutorily and contractually obligated to "ensure" the linguistic proficiency of physicians and their office staff, we recognize the potential reluctance of this group to be assessed or tested for a variety of reasons.

The Alliance will explore creative means to encourage cooperation by physicians that might include the following:

- For those with a baseline proficiency which may still not qualify for proficiency in a patient setting, a short series of classes could be offered to raise their language skills to a level that might allow them to successfully qualify;
- Continuing Medical Education (CME) credits may be sought for physicians who participate in the classes described above; and
- The Alliance intends to conduct a series of analyses that will measure the relationship of language and medical utilization as part of its ongoing quality improvement program.

All of the above efforts are but part of a larger organization-wide program to address cultural and linguistic needs.

The Alliance welcomes opportunities to collaborate with community based organizations in the furtherance of the above stated programs and goals.

For example, the Alliance a) utilizes the Language Cooperative of Asian Health Services as its primary vendor for health interpreters, b) contracts with medical and research experts as external consultants in the development of measures and testing tools of language and cultural proficiency, and c) supports the California Health Interpreters Association, the National Council of Interpreters in Health Care and other health advocates in the area of language access.

The Alliance recognizes that addressing the problems of language barriers to health services must be a collaborative effort, shared by all interested parties in the healthcare field. The benefits and linguistic skills derived by any physician carry over to all of their patients. The Alliance envisions a future industry-wide adoption of programs such as those described here (particularly the development of uniform measures and testing tools).

Conclusion

The Alameda Alliance for Health's vision of culturally and linguistically appropriate health care extends beyond compliance with requirements from statutes or contracts. The Alliance implements its vision through business practices as part of a coherent and dynamic system, instead of stand-alone services, dependent on a specific individual or department.

Rather than focusing on cultural competency as the final desired outcome, this approach targets the desired outcomes at the member/patient level, provider level, and MCO level. The Alliance's approach to delivering a cultural competency assessment and training program poses unique opportunities as well as challenges. Ultimately, the Alliance's approach to promoting health care delivery that is culturally and linguistically appropriate yields the benefits of institutionalization and sustainability of the interventions.

KAISER PERMANENTE®

KAISER PERMANENTE

Description of the Organization

Kaiser Permanente is America's largest not-for-profit health maintenance organization, serving 8.1 million members in 9 states and the District of Columbia. Kaiser Permanente California serves more than 5.9 million members throughout the state. More than 7,000 Permanente medical group physicians in both The Permanente Medical Group (TPMG) in Northern California and the Southern California Permanente Medical Group (SCPMG), as well as 55,300 Kaiser Foundation Health Plan and Hospitals employees, provide care to Health Plan members. There are 28 major medical centers organized into 12 service areas throughout California.

Kaiser Permanente, California serves a membership comprised of 6% Asians, 10% African Americans, 19% Latinos and 60% Caucasians. An integrated health delivery system, Kaiser Permanente organizes and provides or coordinates members' care, including preventive care such as well-baby and prenatal care, immunizations, and screening diagnostics; hospital and medical services; and pharmacy services.

As a not-for-profit organization, Kaiser Permanente states it is driven by the needs of their members and their social obligations to provide benefit for the communities in which they operate, rather than the needs of shareholders. Social benefit activities include assistance to the uninsured and special populations; training new health professionals; introducing new deliver and financing methods into the health care arena at large; and through their clinical research efforts, developing and sharing better ways to care for patients.

Caring for the Uninsured

Kaiser Permanente is committed to improving the health of the uninsured through programs that subsidize coverage for care. They established the Dues Subsidy Program in 1990 to offer coverage for low-income, uninsured individuals who re not eligible for other health coverage. The program offers transitional help for those who are in financial need but are not eligible for other health coverage, including Medicaid or Medicare. In 2001, we spent over $37 million annually to subsidize health care

coverage for uninsured and underinsured children, with a goal of providing subsidized coverage for 70,000 children each year.

In California Kaiser Permanente made a $100 million commitment to cover up to 50,000 children from low-income families for five years beginning in 1998. The *Kaiser Permanente Cares for Kids Child Health Plan* is part of a multi-pronged effort to provide universal health coverage to the children of California. The plan targets low to moderate income working families who are not eligible for Medi-Cal or California's Healthy Families Program, and whose parents do not receive subsidized dependent coverage through their employers.

MEMBER AND COMMUNITY SERVICES

The San Francisco Center of excellence in Linguistic Services

The San Francisco Center of Excellence in Linguistic Services provides high quality and comprehensive interpretation and translation services to its diverse membership. The Center established:

Language specific primary care modules (Spanish and Chinese)

An on-site interpreting unit providing services by a group of certified health care interpreters who are proficient in different languages and dialects;
An interpreter call center for Spanish and Chinese speaking members throughout Northern California; and

A translation unit providing services, e.g., bilingual newsletters (Spanish and Chinese versions) published semi-annually, tri-lingual reference manual (English, Spanish and Chinese medical terminology and diagrams of body systems). And, translation services (consent forms, health care articles, signage, physicians' letter, biographies, surveys, promotional materials, press releases, etc.) for different medical centers and offices of the Program.

In addition, the Center, in partnership with the City College of San Francisco, developed a model health care interpreting program that has set national standards for the certification of health care interpreters.

Kaiser Permanente Latino Association (KPLA) of Northern California

KPLA's commitment is to the delivery of affordable, quality health care. The mission is to attract, inspire and support Latinos to achieve their full potential at all levels with the Kaiser Permanente Medical Care Program, thereby enhancing our ability for shared success.

KPLA awards annual Grant Scholarships to Latino students pursing health career paths and serves as Student Mentors. In addition, KPLA provides education to staff regarding cultural competency, organizes a bi-annual Domestic Violence Conference with other Employee Associations and supports the annual Su Salud Health Fair in Stockton.

Kaiser Permanente Health Phone

Members can listen to free, confidential recorded health messages 24 hours a day. This service is available in both Spanish and English. Call 1(800) 33 ASK ME or 1(800) 332-7563 to listen to recorded health messages 24 hours a day.

Neighbors In Health (Vecinos de Salud) Health Fair of Stockton

The Neighbors in Health Fair is a free community annual event sponsored by Kaiser Permanente Stockton, in partnership with area businesses and non-profit organizations. More than 500 physicians, nurses, and other health professionals and staff provide free health care and screenings for thousands of uninsured residents. Services or the uninsured will include health educations, immunizations and vision checks for children, mammograms, breast exams, foot screening, dental checkups, prostate exams, body-fat testing and screening for diabetes, high cholesterol and sexually transmitted diseases. Health educations, family entertainment and counseling services are also provided. Simultaneously, the Kaiser Permanente Manteca Medical Offices offer a free pediatric clinic for uninsured children in the Manteca community.

Watts Counseling and Learning Center

Kaiser Permanente established the Watts Counseling and Learning Center in 1967 to provide counseling and educational services to the people living in the Watts district of Los Angeles. Services are provided, mostly free of charge, to anyone residing within a six-mile radius of the facility - - KP members and non-members alike. Individual family, marital, parent-child and group therapies are available in English and Spanish.

A program under the Watts Counseling and Learning Center, the Baldwin Park Educational Outreach Program is a free community service provided by Kaiser Foundation Hospitals to young people and their parents.

Working collaboratively with the City of Baldwin Park, most program activities take place in the Baldwin Park Community Center after school, in the evenings or on Saturdays. The programs (offered in English and Spanish) include homework assistance, study skills classes, self-esteem workshops, reading improvement classes, mother-daughter workshops, parenting classes, "home alone" safety workshops, and CPR and

babysitter training. In the summer, middle-school students may attend a six-week science enrichment-learning program integrated with recreational, social and arts activities. Community children also have the opportunity to receive scholarships to residential summer camp through special funding from the Los Angeles Times.

PUBLICATIONS

The Kaiser Permanente Provider's Handbook on Culturally Competent Care: Latino Population

The Kaiser Permanente Provider's Handbook on Culturally Competent Care: Latino Population provides an ethno-cultural overview of the health beliefs and behaviors, risk factors and major diseases of the Latino population. This fifty-five page second edition handbook is designed for clinicians as an easy reference tool to raise awareness and education levels on the multi-dimensional aspects of providing care to Latinos.

Member Health Education Materials

A Menopause Guidebook in Spanish, "*La Menopausia… Como Enrequesar Su Salud a Mediados de la Vida,"* contains definitive information on menopause, including: hormone replacement therapy, breast cancer, osteoporosis, heart disease, sexuality, mental health, complementary and alternative medicine, and menopause and midlife health resources.

Kaiser Permanente Healthwise Handbook (La Salud en Casa)

This is a self-care guide for Kaiser Permanente members and their families available in English and in Spanish.

Grant Awards

In 2000, El Concilio of San Mateo County and Sonoma County People for Economic Opportunity (SCPEO) Children's Health Center received a $25,000 grant from Kaiser Permanente's Growing Healthy Communities Grant Program to further their work with families learning to manage two of the most rapidly spreading and treatable disease in California - - diabetes and asthma.

El Concilio of San Mateo County's grant will be used to fund the outreach expansion of its major health project, Nuestro Canto de Salud (Our Song of Health) to more patients with diabetes. Through these programs, El Concilio has provided the Latino community with culturally focused, community based health information, services and interventions.

LA Care Health Plan

Description of the Organization

Addressing the Needs of an Ethnically Diverse Membership

Studies have shown that language and cultural issues can pose significant obstacles to patients seeking healthcare. This is especially important in Los Angeles County, where one-in-three residents are foreign-born. L.A. Care Health Plan (L.A. Care) is a public health maintenance organization that serves more than 800,000 Los Angeles County residents with diverse ethnic and language backgrounds.

These individuals receive healthcare services through their enrollment in Medi-Cal (California's Medicaid program), Healthy Families (California's State Children's Health Insurance Program) and California Kids (a program funded by foundation grants and L.A. Care serving low-income children not eligible for Medi-Cal or Healthy Families).

As one of California's largest HMOs, and the nation's largest public managed care plan, L.A. Care faces many challenges as it strives to provide access to competent care that is both culturally and linguistically sensitive. Consider the following:

- L.A. Care members speak more than 30 languages.
- About 52 percent of members are most comfortable speaking a language other than English.
- L.A. Care members represent 17 primary ethnic groups.
- More than half of physicians responding to a survey conducted by L.A. Care in 2001 reported relying on patients' family members and friends to interpret for them.

Challenges Posed By an Ethnically Diverse Membership

To address the unique challenges posed by an ethnically diverse membership, L.A. Care is one of few health plans in the country that has a dedicated Cultural & Linguistic Services Department.

Established in January 2000, the Department works to ensure that members receive care that is appropriate to their needs. For example, L.A. Care's member materials are available in English, Spanish, Armenian, Khmer (Cambodian), Chinese, Russian, and Vietnamese. Providing member materials in appropriate languages is a significant step in meeting member needs because a majority of L.A. Care members are immigrants who have limited English proficiency.

The Department has also developed policies, interpreter training, translation services and cultural competency training to assist provider partners in better serving their patients. For example, the Department offers physicians, clinics and their staff training in cultural competency; participates in local, statewide and national committees relating to cultural competency in healthcare delivery; provides cultural awareness and sensitivity training; and offers access to interpreter services at medical and non-medical sites.

As part of its commitment to assisting health care providers better understand the needs of a diverse population, the Department began offering free training in quality interpretation to L.A. Care's affiliated physicians and their staff. The "Health Care Interpreter Program" seeks to prevent any misdiagnosis, wrongful testing, inappropriate treatment and patient non-compliance that can occur as a result of misunderstanding due to the absence of a skilled interpreter.

Healthcare Services to Latino Population

As of August 2002, over 60 percent of L.A. Care's member population was comprised of Latinos. As such, L.A. Care offers healthcare services to its Latino membership through a variety of programs. In addition to Medi-Cal and Healthy Families, L.A. Care has helped insure thousands of Latino children through collaboration with the California Kids Healthcare Foundation. These children do not qualify for Medi-Cal or Healthy Families.

L.A. Care also provides healthcare services to many Latino children at-risk of abuse and neglect through the "L.A. Cares for Kids" program, where a nurse visits children's homes and ensures that they receive proper care.

In addition, the organization supports the training of specialized community health workers called "Promotoras." These health care workers deliver care and provide vital health information in Spanish to low-income Latinos who speak little or no English.

L.A. Care is also involved in a program that helps Latino youth to learn more about careers in healthcare. Through "Jovenes por la Salud", L.A. Care provides internships to Los Angeles area Latino high school students, who are able to get a first-hand look at the inner-workings of the healthcare industry.

Steps Taken to Address Members' Linguistic Needs
Because of the unique needs of its members, L.A. Care has an established Community Outreach & Education Department. This Department oversees the operations of 11 Regional Community Advisory Committees (RCACs). The RCACs are comprised of L.A. Care members from many ethnic backgrounds, healthcare advocates, provider and community representatives. RCAC members act as advisory groups whose mission is to improve the health of their respective communities.

With a large Latino makeup of its member base, L.A. Care provides free interpretation services in Spanish to RCAC members who do not speak English. In addition, three of the 11 RCACs conduct their monthly meetings entirely in Spanish. Furthermore, a full-color quarterly RCAC newsletter that highlights RCAC accomplishments is available to members in Spanish. L.A. Care also employs a Call Center staff that assists members and callers by providing important health plan-related information in eight threshold languages, including Spanish.

Support and Recognition by The California Endowment
Recognizing the value of its work, The California Endowment, which is the state's largest healthcare foundation, provided the Department with a $528,523 grant in 2002 to help strengthen its ability to assist patients with limited English proficiency. The grant will enable the Department to supply L.A. Care healthcare providers with important information on how they can meet their patients' language needs, as part of efforts to enhance patient satisfaction.

One project calls for L.A. Care to identify key documents that will be translated into six major languages spoken by members – Spanish, Armenian, Khmer (Cambodian), Russian, Chinese and Vietnamese. The intent is to place these commonly used documents – such as informed consents or letters of denial – online, where health care providers can download them and personalize them to their respective patients.

Another project funded through this grant calls for L.A. Care staff to travel to physician offices and provide doctors and their staff with valuable training aimed at improving their working relationships with interpreters.

Conclusion

With a dedicated Cultural and Linguistic Services Department, L.A. Care Health Plan continues to be committed to its mission to provide quality health care programs and services tailored to meet the healthcare needs of Los Angeles County's culturally and linguistically diverse population.

HEALTH PLAN FOR - PROFIT

HEALTHNET

Description of Organization

Health Net is a recognized leader in the area of health management programs designed around the goals of improving quality of life, reducing disease severity, alleviating absenteeism, and reducing acute utilization. Our population-based medical management strategy is one of our core competencies and we strive for continuous improvement.

Health Net provides innovative health plan benefits to employers and individuals, including Salud con Health Net, Medicare and Medi-Cal beneficiaries and members of the Healthy Families and Aid to Infants and Mothers programs.

Total Population Served in California

With over 2.6 million diverse memberships in California, primarily comprised of Latinos, Caucasians, Asians and African Americans. Health Net provides services for Medicare, Medicaid, Healthy Families, AIM and commercial members. Health Net analyzes the composition of its communities to provide culturally and linguistically appropriate services. Each county within the State of California has a unique mix of ethnic cultures. In some counties Health Net has large numbers of members among the Russian, Iranian, Vietnamese, Korean and Hmong communities.

Programs Specifically Designed to Serve Latinos

Health Net is committed to increase enrollment in California's growing ethnic markets. A recent Latino Market Assessment study conducted by the Healthcare Redesign Group revealed facts about the projected growth of the Latino community in California over the next several years, Latinos' economic prosperity, spending patterns and their health insurance status. Based on the findings of this study and Health Net's internal research, Health Net of California undertook a series of initiatives to increase services to the Latino community.

Salud con Health Net

This is a bi-national health plan option delivered in partnership with Hispanic Physicians IPA, Tenet Health Systems and Sistemas Medicos Nacionales, S.A. (SIMNSA), a Mexican health plan that is licensed by the Department of Managed Health Care in the State of California. These Health Net partners offer affordable, high-quality health care to the Latino community in a cultural and linguistically sensitive manner.

The program was designed with a far-reaching vision that affirms our commitment to social responsibility and addresses the needs of this often underserved population. Health Net is unique in this commitment and it helps differentiate Health Net from its competitors. The program presents great synergies in packaging with the highly successful California Health Programs, which provide benefits to publicly sponsored programs. The Salud con Health Net name has now been expanded to serve as our national brand for services, products, outreach and marketing strategies targeting the Latino community.

Salud con Health Net

- addresses the needs of many uninsured and underinsured members of the Latino community by:
- Offering an innovative new package of health insurance products designed to improve accessibility, affordability and quality of health care for Latino families
- Addressing the unique needs of Latino families with culturally sensitive products and services
- Offering the first truly cross-border feature in a health insurance product, which provides access to health care services on both sides of the border
- Providing employers the opportunity to offer Latino employees and their family members a health care program specifically designed to provide access to quality health care at a very affordable level
- Combining our employer-sponsored plans with access to the Healthy Families program
- Contracted community health care providers specializing in culturally sensitive health care

When it comes to health care needs, Latinos tend to be very cost-conscious and love convenience. They enjoy the one-stop "clinicas" in their communities, like those operated by our partners Hispanic Physicians IPA and SIMNSA. Hispanic Physicians IPA and SIMNSA have ancillary services, including lab, pharmacy and outpatient surgery facilities, along with extended office hours (nights and weekends) and have fully bilingual staff.

Spanish-speaking Health Net health educators provide health screenings and health education information at community events and health fairs. Brochures and booth signage is provided in Spanish.

Spanish-Speaking Health Net health educators provide child car seat clinics to parents of young families. They educate the event attendees on the new traffic laws pertaining to child car seat regulations and provide instructions on the correct type of car seat that their child(ren) should use . The bilingual fotonovela "Mas Vale Prevenir Que Lamentar" is distributed free to the public.

Spanish literature on a variety of topics, including health education and plan benefits

Our Spanish Web site, www.saludconhealthnet.com was designed and developed specifically for the Latino culture. The site provides information similar to its English counterpart, www.healthnet.com, it includes:

- Health plan benefit information
- Preventive health information
- Information on culturally sensitive health issues
- Health-conscious Mexican recipes
- Instructions in Spanish and English on how Health Net members may access our Nurse advice Line, our 24-hour medical advice line staffed by registered nurses, as well as instructions on how to call from Mexico
- Numerous downloadable Spanish language brochures, including Health Net's award-winning fotonovela "Mas Vale Prevenir Que Lamentar"
- Link to "DocSearch," Health Net's database of contracting medical providers, which allows searches based on doctor's language capabilities.
- Downloadable Spanish-language brochure on the medications that appear on Health Net's Recommended Drug List (formulary)

Health Net focuses on identifying the bilingual needs of each community and building a bilingual provider network throughout the state that meets the cultural and linguistic needs of Health Net members.

Outreach to Latino communities through active participation and sponsorship of events such as health fairs, shows, community events, meetings and conferences on issues of concern to the Latino community. In Southern California, Health Net's wellness van visits community events to provide information in Spanish, including a nutrition booth that is staffed

with Spanish-speaking health educators that focuses on the fat content of typical Latino food items.

Health Net has identified four main audiences to promote initiatives that are designed to better serve the Latino population:

- Employers or Latino business owners – manufacturers and service-related industries with large Latino populations
- General agents and brokers – via regional broker breakfasts, broker blast faxes and industry periodicals
- Community-based organizations – participation with organizations like the Latin Business Association (LBA), California Hispanic Chamber of Commerce, local chambers of commerce in communities with a large populations of Latinos, elected officials and advocacy organizations with a mission to offer affordable health care options to uninsured Latinos

Health Net offers workshops to inform its own associates and the doctors and medical professionals within its provider networks of the cultural and linguistic needs of the Latino community.

Special Programs for The Uninsured

There are two programs for low-income adults and children – Healthy Families and Medi-Cal. Healthy Families offers low-cost health coverage for children who do not have insurance and do not qualify for no-cost Medi-Cal. The program provides complete medical, dental, and vision coverage to qualifying children. Qualifying families pay a monthly premium of $4 to $9 for each child, up to a maximum of $27

Health Net provides the Healthy Families program in 44 California counties. In five of those counties, Health Net is the designated Community Provider Plan. Health Net currently has more than 83,000 Healthy Families members. What sets Health Net apart from other Healthy Families providers?

Health Net offers its Healthy Families members:

- Chiropractic and acupuncture benefits
- Mail-order prescriptions
- A 24-hour nurse advice line
- A 24-hour health education and nutrition line
- An infant car seat for mothers who complete prenatal education classes, and, most importantly,
- A large number of quality hospitals and health care providers to choose from.

Medi-Cal is for low-income families and many people who are disabled or over 65. For most beneficiaries, the Medi-Cal program covers most health care services at no charge.

In San Diego, Sacramento, Fresno, Tulare, and Los Angeles counties, Health Net has worked with state officials to develop Medi-Cal managed care programs that provide beneficiaries with the same access to quality care and service that Health Net provides all of its more than 2 million members. In San Bernardino and Riverside counties, Health Net Medi-Cal benefits are provided to members through Molina Healthcare. Health Net currently has more than 620,000 Medi-Cal members.

Health Net is involved in many outreach efforts and activities in communities targeting ethnic and low-income populations. With their car seat program, they discuss and educate the public on child passenger car safety and booster seat use. Car seats are given away with installation training at community events.

Health fairs & activities – health fairs are held in predominantly lower-income neighborhoods at no cost to the participants to help increase awareness of health issues and wellness. In addition, Healthnet provides free information, health screenings and resources, including no-cost sources for medical treatments and services, to fair goers who are encouraged to follow up with health, wellness and healthy lifestyle practices.

Healthnet raise uninsured patrons' awareness of California government health insurance programs (specifically Medi-Cal and Healthy Families) and assist them in enrolling in a qualified program if help is needed. Among others, Health Net participates in:

- Procter & Gamble Food 4 Less Health Fairs
- Von's Grocery Stores Health Fairs
- Chinese New Year Festivals
- TET Festival
- Children's Health Expo
- Fiesta Filipina
- 2002 Philippine-American Expo
- Orange Blossom Festival
- Compton Athletic Games
- Black History Month Business Expo
- Los Angeles Unified School District Healthy Families enrollment fairs
- Other school-based events

- Provider Open House
- Kid's Care Fairs

Health Net has built strong relationships with partners committed to making health care more accessible to the different communities it serves. Some of the Health Net partners include:

- Community-based organizations or agencies
- Chambers of commerce
- Parks & recreation departments
- Churches
- School districts
- Brokers
- Employer Groups
- Women, Infants and Children (WIC)
- National Association of Women Business Owners
- YMCA
- Head Start

Other programs for the underserved community include:

- Healthy Families Grant Program:

For the third year, Health Net's Healthy Families program has provided grants to medical groups to help them better address the needs of the Healthy Families members. Funding is provided for services to:

- Improve access to care
- Enhance coordination of care
- Improve encounter data collections and reports
- Increase physicians' cultural and linguistic capabilities (such as special population communications and health-related materials that are culturally and linguistically appropriate).
- Heighten physicians' knowledge and skills to meet the needs of the underserved through the development of managed care opportunities.

Examples of grants include funding for:

- Extended medical clinic hours
- Health educator positions
- Creation of culturally & linguistically appropriate education to members and medical providers
- Care and education coordinator positions
- Patient advocate positions
- Development of diabetes education programs

- Development of child obesity programs
- 24-hour interpreter services
- Rural & inner-city transportation vans and programs
- Information and resource centers
- Member retention programs
- Immunization programs
- Pre-natal guides for Hispanic women
- Medical translators

Special Publications for Latinos and other people of color and the languages featured

Award-winning bilingual fotonovela on car seat safety for Latino audiences, "Mas Vale Prevenir Que Lamentar." The fotonovela depicts a story about a Latino family who learns about the safety benefits of child safety sets and boosters, traffic laws and safety precautions needed to protect their young children. This handy booklet also includes a resource list for correct guidance on child seat use.

Spanish-language prenatal care program and parenting support materials designed for Latino consumers.

Plan benefit information and preventive health information provided in Spanish and Chinese (traditional Chinese characters used in written documents for readability by all Chinese dialects). Some preventive health and wellness information is available in Korean, Vietnamese, Russian, Farsi, Armenian, Hmong, Lao and Braille.

DocSearch,

The Healthnet online provider database located at www.healthnet.com provides the user with information on Health Net's more than 40,000contracted physicians. Searches may be done by physician's name, specialty, medical group, gender, geography, and language spoken.

Baby Basics

Health Net sponsorship of the Spanish translation of "Baby Basics," a prenatal guide written to provide accurate, clear information to a Latino audience. "Baby Basics," produced by the What to Expect Foundation, is based on the bestseller "What to Expect When You're Expecting." "Baby Basics" was written to address the diversity of prenatal experiences by both men and women from various socioeconomic backgrounds and literacy levels.

Language Access Services:

Member Services

Health Net provides interpreter assistance for all members with limited English proficiency to facilitate access to health plan benefits and services. Additionally, Health Net features an in-language Member Services unit dedicated to providing information in the following languages/dialects: Spanish, Cantonese, Mandarin, Korean, Vietnamese, and Tagalog. Health Net also provides information to hearing-impaired individuals with access to TDD.

Health Net utilizes commercial interpreter vendors in support of those members that may have linguistic needs outside of the language services provided by Health Net's Multilingual Services.

Community outreach

Healthnet's commitment to the community is demonstrated by its support of community-based organizations and the sponsorship of neighborhood events such as health fairs, informational meetings, business expositions, and power luncheons. In addition, Health Net provides valuable health information through its Worksite Wellness program for members with employer-sponsored coverage.

Healthnet's Medi-Cal and Healthy Families programs are supported by direct input from the community through established community advisory committee meetings. Health Net hosts community advisory committee meetings four times a year in each county within the state where it provides Medi-Cal benefits. Any Health Net Medi-Cal or Healthy Families beneficiary is welcome to participate and offer input to the development of health education materials, culturally appropriate services and services to address the linguistic needs of the community.

Publications

- Provider directories, with translated information on how to use the directory, and identification of health care providers who speak languages other than English
- Translated member handbooks on how to access care
- Numerous health improvement brochures
- Specific programs for prenatal care, weight management and asthma

Translation

Healthnet "transcreates" documents to ensure that the information provided in the reader's language is culturally sensitive pertinent to readers who do not have command of the English language. Contracted translators are certified by the American Translation Association, while all translated documents are carefully checked to be sure accuracy and account for regional dialect differences and contain thorough definitions on health care industry terminology.

HEALTHCARE ASSOCIATIONS

CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

Description of the Organization

Mission

The California Association of Public Hospitals and Health Systems, a non-profit trade organization representing California's public hospitals and health systems since 1983, works to strengthen the capacity of its members to advance community health, ensure access to comprehensive, high-quality, culturally sensitive health care services for all Californians and educate the next generation of health care professionals. Our passionate belief that everyone deserves an equal opportunity to enjoy good health – regardless of their insurance status, immigration status or ability to pay – drives our policy and advocacy agenda.

Membership

CAPH represents more than two dozen hospitals, health care systems and academic medical centers in 18 counties – including each of the 15 most populated counties – throughout California. Also called "open door providers" because no one is denied access to the essential health care services they provide, CAPH members share a mission and mandate to provide care to all residents, regardless of their ability to pay. Among the members of CAPH are county-owned and operated facilities, University of California medical centers, and private, not-for-profit facilities sharing a common commitment to serving all people.

What is an "open door provider"?

An open door provider is a hospital, academic medical center, community-based health center or other entity dedicated to assure the accessibility of cost-effective, high quality and culturally appropriate health care services for low-income and uninsured populations, *beyond those emergency and stabilization services required by law.* Open door providers also ensure the availability of critical public goods, such as trauma and burn care, essential to the health and well-being of the public-at-large.

Unique Services

The intricacies of public health care policy and legislation are often complex and confusing. CAPH serves as a resource for information and assistance on a variety of state and federal health care policy issues. With highly trained professional staff CAPH is available to respond to inquiries from legislators and their staffs, administration officials, members of the media, healthcare stakeholders, the general public and, of course, members and their staffs on a wide-range of issues, especially those affecting California's low income and uninsured populations.

Description of Population Served

The California Association of Public Hospitals and Health Systems members:

- Deliver 87 percent of the state's outpatient care to the medically indigent, and
- are located in counties containing 88 percent of all Californians; constitute 10.5 percent of the state's hospital beds;
- train almost half of the medical residents in the state;
- serve a patient population that is 76 percent of people of color;
- deliver 27 percent of the state's inpatient care to the Medi-Cal population;
- handle 32 percent of the state's Medi-Cal neo-natal intensive care;
- serve a patient population that is 70 percent low-income;
- provide 11 million outpatient clinic visits annually;
- provide 61 percent of the state's burn care;
- provide 63 percent of state's psychiatric emergency care;
- deliver 74 percent of the state's inpatient care to the medically indigent.

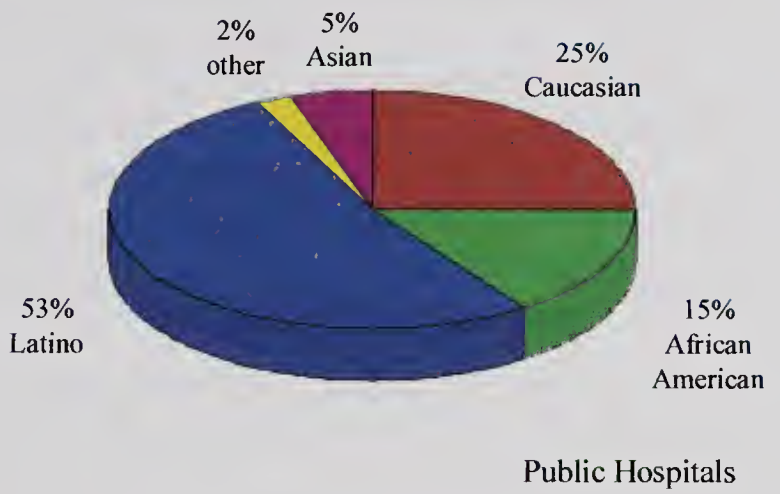
The patient's served by the CAPH members is one of the most diverse. Based on discharge data from the Office of Statewide Health Planning and Development for calender year 2000:

76% of the patients served by public hospitals are non-white

- 53% Latino; 25% Caucasian; 15% African American; 5% Asian; 2% Other

Patient Population

Inpatient Services - Patient Racial/Ethnic Distribution



Public Hospitals

*OSHPD hospital discharge data abstracts 2000.

Please note these are inpatient statistics. Although there is no data available for the outpatient side we believe it is intuitive that the same proportion would be served on the outpatient side.

The California Health Care Safety Net Institute

The California Health Care Safety Net Institute is a 501(c)(3) research and education affiliate of the California Association of Public Hospitals and Health Systems dedicated to enhancing the capacity of open door provider's and their strategic partners to advance community health.

The Institute had identified the problem of racial/ethnic disparities in health as a primary focus of its community health agenda. Research shows that racial minorities tend to have poorer health status, poorer access to health services, and poorer health outcomes. While research reveals stark differences, relatively little is understood about the underlying social, economic and medical factors contributing to these disparities. With the Census Bureau's recent announcement that California's minorities are now the majority, the importance of this issue takes on new urgency.

Open door providers throughout California serve a patient population that is over 80 percent minority. As such, these providers are making a special effort to improve cultural competence in their systems. A few examples of the innovative approaches they are taking follow:

Viewing the health care system through the eyes of non-English speakers and making changes in the way the system communicates with patients. Reducing health risks for specific ethnic groups through community based health promotion programs.

Instituting cultural competence training for employees.

Highlighting and celebrating the cultural diversity of communities through special events and other activities.

In the spring of 2001, the Institute updated an earlier survey of the efforts of California's open door providers to promote culturally competent health care. The Institute has developed a comprehensive list, *QuickGuide to Competence Programs at Open Door Providers,* of innovative programs that indicate the organizations and contact persons for programs that are:

- programs focused on creating change at the institutional level,
- aimed at addressing the needs of a particular population
- may also focus on a certain service, such as psychiatric services, or
- a particular health problem like diabetes.

The list is updated frequently. Information on this list of specific programs can be obtained by writing, calling or emailing to:

California Health Care Safety Net Institute
2000 Center Street, Suite 308
Berkeley, California 94704
(510) 649-7654
(510) 649-1533 fax
www.safetynetinstitute.org

Director: Wendy Jameson, MPH, MPP
wjameson@caph.org

Observations and Areas for Further Inquiry

The Impetus for Change

Contrasting the origins of these programs provides a glimpse of what drives change. Clear data and a growing recognition of the problem of Black infant mortality and morbidity drove the establishment of the state-run Black Infant Health program and the application counties like Los Angeles and Riverside to apply for these funds.

Other efforts, such as Su Salud, a community-based organization that established a clinic at San Joaquin General Hospital, grew out of grass-roots, local recognition of emerging Latino health needs and a unique and innovative partnership between a community-based organization and a public hospital. The Refugee and Child Health Program within the Santa Clara Valley Health and Hospital System, like most refugee health programs, emerged as a unique role of public health systems because of their status as an arm of local government with a mandated responsibility to ensure access to health care for refugees.

State-wide Changes

Beyond making improvements in individual staff/physician knowledge of and attitudes and sensitivity towards ethnic/cultural/language differences, what system changes are important for increasing cultural competence in health care? Open door providers in several counties have undertaken system-wide approaches to assess and enhance cultural competence. For example, the Los Angeles County Department of Health Services (DHS) created the Office of Diversity Programs to establish systems that promote cultural competence throughout DHS. Cultural diversity is addressed using an approach that ensures consistency in staff training yet allows for unique local approaches.

To ensure that all 23,000 employees are exposed to the concepts of cultural competence, Los Angeles County DHS has mandated four hours of training on "unlearning prejudice" for all employees and developed a Cultural Competency Certificate Program for senior managers. In addition, its Diversity Operations Council collaborates with the Office of Diversity Programs and local councils in eight regions throughout the county, often based at public hospitals, to implement DHS' diversity strategic plan.

Santa Clara Valley Health and Hospital System's Public Health Department took a different approach to improve the cultural competence of its workforce. Administration felt that before implementing system-wide changes as part of its overall redesign effort, the department needed to assess its own level of cultural competence as an organization and identify what was needed in order for the system to be more culturally competent and accessible to diverse populations.

In 1999 it created aDAPT (a Diversity Action Planning Team) comprised of representatives from various department divisions that assess the cultural competence of the department and makes recommendations for improvement. San Joaquin County Health Services took a similar approach in developing its Mental Health Cultural Competency Plan,

which involves a comprehensive review of the problems of access to mental health services for various ethnic/language minorities.

Getting Down to Basics

One of the most basic and effective strategies for increasing organizational cultural competence is to build a staff that closely reflects the racial, ethnic, and linguistic composition of the populations served. Some public health care systems have made a serious commitment to hire more staff who are bilingual and from diverse racial/ethnic backgrounds. For example, Riverside County Health Services has set targets to increase its bilingual staff (primarily Spanish/English) to 35 percent of its Medically Indigent Adult Services program staff and 45 percent Provider relations staff.

It bears further investigation to determine what strategies have been used to increase the diversity of the public health care workforce shortages. A particular challenge for providers in some geographic areas, such as Riverside County, where Spanish is the primary spoken language for a large proportion of patients, is recruiting Spanish-speaking nurses. Data indicate that Latinos represent 28 percent of the working age populations in California but only five percent of the active California registered nurses.

When matching patients and providers by language is not possible, effective interpretation is essential. While most health care systems in California provide some interpretation services, many open door providers have such widely divers patient populations that they have developed very extensive services to ensure language access. For example, interpretation in 14 languages is available on-site at San Francisco General Hospital.

Santa Clara Valley Health and Hospital system has created a separate service called Valley Connections that provides interpretation services and translation of written materials for patients. Contra Cost Health Services has a Cultural and Linguistic Team that addresses various issues related to linguistic access for patients, including development of a training curriculum for interpreters in eighth languages. Working in partnership with the organization Health Access, Alameda County Medical Center and the Community Health Network of San Francisco are pilot-testing state of the art videoconferencing technology that provides patients and clinicians with face-to-face support in multiple languages from medical interpreters who may be located on or off-site.

Given the vast experience of open door providers in addressing language access needs, much could be gained by taking a closer look at what has been learned in the public sector regarding how to build effective

interpretation and translation services in the health care system. Included in this inquiry could be an assessment of emerging models for effective medical interpretation, including innovative partnerships with ethnic-oriented community based organizations, and an analysis of how these services are financed. The answers to these questions are especially relevant given the recent issuance by the US Department of Health and Human Services of written policy guidance for federally funded health care providers to ensure language assistance for persons with limited English skills.

Need for Evaluation

The Institute's survey raised a number of questions related to the evaluation of cultural competence programs.

- Do employee diversity training programs work?
- What are the variants that affect how well they work, e.g., duration, intensity, targeted to actual job specifications, repetition or tied to job promotion or compensation?
- Do targeted programs serving specific populations and focused on particular disease produce better health outcomes than would be obtained through a traditional health care setting?
- How best can lessons learned within a population-specific, targeted program be disseminated to the larger provider network, staff, and system?
- What are the benefits to the patients and the provider of these kinds of programs in terms of patient satisfaction, patient retention, improved communication, appointment keeping, etc.?

The answers to these and other questions are central to ensuring that the health care needs of our increasingly diverse population can be met.

Conclusion

The Institute's report provides a scan of the important efforts underway at open door providers to promote cultural competence in a health care setting. Admittedly, it asks more questions than it answers. With growing interest in learning more about factors that improve the quality of health care for diverse populations, it is hoped that further research will illuminate many of the issues raised through the survey. The California Health Care Safety Net Institute and its affiliate, the California Association of Hospitals and Health Systems, look forward to continued involvement in efforts to ensure that California's "minority majority" has access to culturally and linguistically appropriate health care services.

CALIFORNIA MEDICAL ASSOCIATION FOUNDATION

Description of the Organization:

The CMA Foundation primarily began in 1963 as a charitable arm of the California Medical Association, disbursing over $1 million dollars in grants and loans to medical students. The CMA, while supporting the interests of California's physicians, realized that it was important to help along future physicians during their educational years, and so remained as a source of resources for medical students until 1995, when Dr. Rolland C. Lowe, M.D., CMAF Board Chair, recommended that the Foundation expand its role to encompass community health.

Mission

The CMA Foundation, a partnership of leaders in medicine, related health professions and community, supports advances in individual and community health.

To fulfill their mission, the CMA Foundation acts as a bridge linking physicians to their communities. We work in collaboration with all of our many partners to achieve significant improvement in key health issues. We receive funding for our projects through physician, corporate, and foundation support.

Goals

The CMA Foundation pursues the following goals to ensure the fulfillment of their mission:

- Build the capacity of physicians and physician organizations to work collaboratively to improve health.
- Create a climate that acknowledges the importance and value of physician involvement in efforts to build healthy communities.
- Provide leadership in crucial and emerging health issues, enabling physicians to provide the best care possible to their patients.
- Serve as a convener of varying stakeholder groups to address critical health issues.
- Strengthen the ability of physicians to work with diverse communities.
- Strengthen and expand education and research programs that focus on health.

New projects began in 1996 and 1997, such as ComPACT (tobacco education) and the Physician Leadership Recognition Dinner. These programs established our position in the community as leaders of public health initiatives.

The Pharmacy Partnership Project, begun in 1996, gathered pharmacists from across California working in independent pharmacies to remove tobacco products from their stores. We realized a nearly 80% success rate (currently 78% of independent pharmacies in California are tobacco free). In July 2000, the Partnership changed its name to Prescription for Change to encourage chain pharmacies to go tobacco free as well. Overall, the mission of this project is to facilitate public education campaigns, advertisements, and media coverage that focus on increasing consumer awareness about pharmacies selling tobacco.

Beginning in 2000, the CMA Foundation initiated its community involvement by launching the AWARE Project (Alliance Working for Antibiotic Resistance Education), a nationally recognized project. In addition, there are many other health projects, public outreach programs, and physician conferences that point to CMA Foundation's commitment to improving the health of California's residents.

Ethnic Physician Project

Background & History

The Ethnic Physician Organization Network is a new coalition of 41 of California's Ethnic Physician Organizations established in June, 2002 at the first Ethnic Physician Organization Summit held in Burlingame, California. The Summit was a milestone of the Ethnic Physician's Project conducted by the California Medical Association [CMA] Foundation and funded primarily by The California Endowment and The California Wellness Foundation.

This project is designed to identify strategies for building the capacity of Ethnic Physician Organizations to reduce health disparities and improve access to health care for their communities through increased collaboration with community organizations and policy advocacy in both the public sector and within organized medicine, and address diversity in the healthcare workforce and cultural competency.

In its initial stages, the Ethnic Physician Organization Network has already achieved a number of significant accomplishments:

- During the Ethnic Physician Summit, Network members coalesced around the health crisis in Los Angeles County and quickly reached

consensus on a collective response to the L.A. County Board of Supervisors.

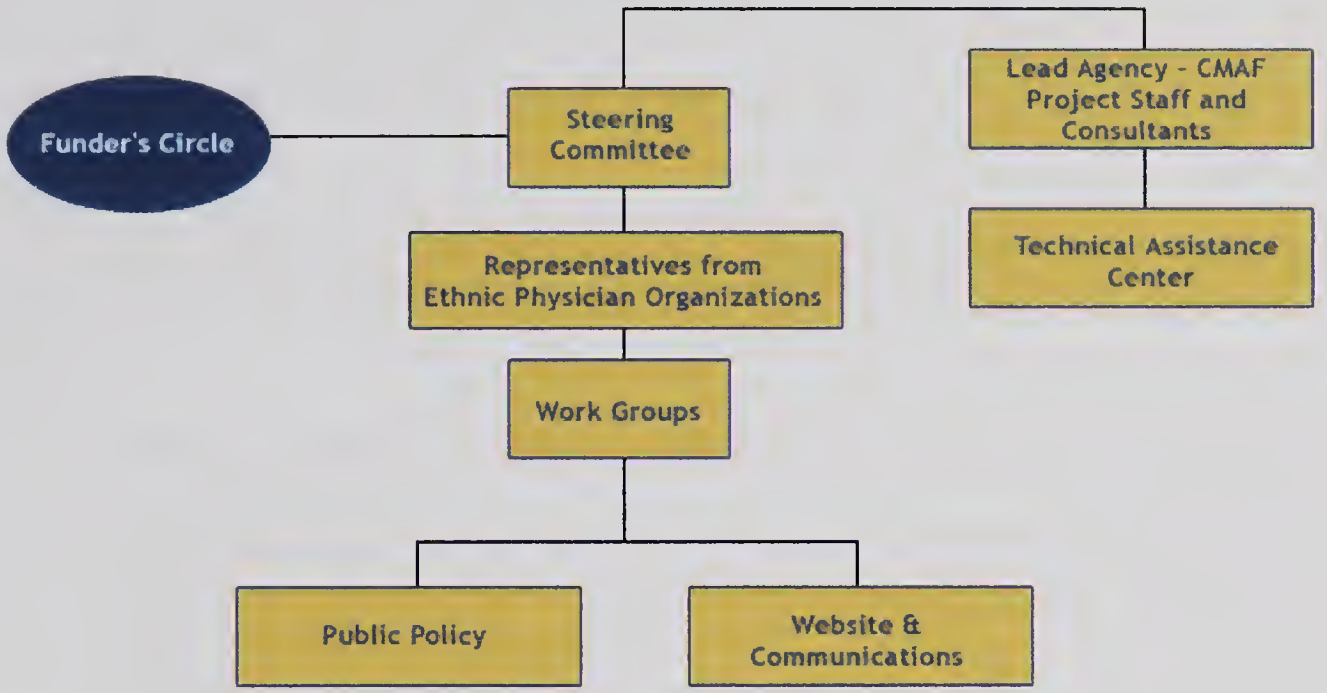
- During the same Summit, the Network defined its strategic direction by identifying four initiatives to address its goals.
- The members of the Network selected an interim Steering Committee that has been guiding the development of the organization in concert with the CMA Foundation.
- Most significant for the long-term development of the Network, the participants at the Summit found common ground as ethnic physicians in California and affirmed the benefits that acting collectively would have for the health of their respective communities.

Goals

Goals of the project include supporting a network of ethnic physician leaders to serve as community health advocates throughout California. Strategies to accomplish this goal are:

1. Strengthen the collaboration between ethnic physician and community-based organizations.
2. Deepen the relationship between physicians and community members to improve the health of their communities.
3. Encourage ethnic physician leadership development at the local, regional, and statewide level.
4. Address the issues of health disparities and access to care.
5. Increase the workforce diversity and cultural competency of California's healthcare system.
6. Encourage and identify young ethnic physicians to become involved in ethnic physician organizations.
7. Encourage ethnic physicians to expand their roles in the local community beyond their role as clinicians.
8. Provide the local community with the ethnic physician's perspective on community health issues.

Organizational Structure



Lead Agency

The CMA Foundation staffs the Technical Assistance Center. The Center provides capacity building, training and support to local ethnic physician leaders to enable them to expand their work in the areas of health disparities, access to care and diversity in the healthcare workforce. Workshops and technical support are provided both statewide and locally. The Technical Assistance Center's capacity-building activities include workshops addressing collaboratively in the community to address health priorities at the local level.

Steering Committee

The Steering Committee is comprised of between 8 to 12 members, representing ethnic physician organizations.
The purpose of the Steering Committee is to:

- During the Ethnic Physician Summit, Network members coalesced around the health crisis in Los Angeles County and quickly reached consensus on a collective response to the L.A. County Board of Supervisors.
- Provide input into the development of training and technical assistance.
- Identify resources that will be used to advance the project's goals.
- Set priorities for the Network.
- Share knowledge and expertise in collaboration, community capacity building and cultural competency.

- Assist in the dissemination of project results and key knowledge, experience and "lessons learned."
- Plan for a "Stand-Alone" Network [i.e. functioning independently of the CMA Foundation].
- Members meet two to four times each year.

Public Policy

All 41 ethnic physician organizations are encouraged to participate in the Public Policy Committee. The purpose of the Public Policy Committee is to:

- Monitor progress in achieving the project's goals and implementing the plan of action.
- Identify issues of concern and those areas where additional education is needed. [For example, how to have a voice in local community and Sacramento.]
- Establish guidelines for the identification of issues.
- Provide written policy briefs on issues from the unique perspective of ethnic physicians.
- Act as a resource to policy makers and opinions on issues such as health disparities, access to care, diversity in the health workforce, and cultural competency.
- Collaborate with community based organizations and others on issues of mutual concern

Website & Communications

All 41 ethnic physician organizations are encouraged to participate in the Website and Communications Committee. The purpose of the Website and Communications Committee is to use technology for:

- Outreach to and working effectively with community organizations serving the same populations they serve.
- Collaborate on policy advocacy issues and activities.
- Share information and resources to promote capacity building
- Increase the ability of Ethnic Physician Organizations to communicate with each other, with their members, and with other organizations.
- Increase their visibility, collectively and individually, among policymakers, community organizations, funders and other potential partners and stakeholders.

Conclusion

The CMA Foundation recognizes the impact of face-to-face communications in healthcare, and they strive to bring healthcare providers, allied health professionals, community organization leaders, health plans, policy makers, and others together with the information they need. This supports efforts for them to more fully understand the ever-changing needs of diverse populations and the healthcare environment. Special events, summits, and conference mark successes in their history of gathering leaders in healthcare and community organization to raise awareness about emerging and important health issues.

CALIFORNIA PRIMARY CARE ASSOCIATION (CPCA)

Description of Organization

The California Primary Care Association (CPCA) is the federally designated statewide association representing a network of more than 500 nonprofit community clinics and health centers (CCHCs) and regional clinic consortia. CPCA's mission is to promote and facilitate equal access to quality health care for individuals and families through organized primary care clinics and clinic networks that, among other things, seek to maintain cost-effective, affordable medical services, as well as meet the linguistic and cultural needs of California's diverse population.

Total Population Served in California

California's CCHCs served over 2.8 million patients in 2000. The following is a breakdown of the CCHC patient population by race and ethnicity:

55%	Latino
6.2%	African American
5.2%	Asian
2.1%	American Indian
0.7%	Filipino
0.4%	Pacific Islanders
4.8%	Unreported

Also, 44.3% of patients served by CCHC's are limited English proficient. Almost 90% have incomes below 200% of the federal poverty level.

(Source: Office of Statewide Health Planning & Development data, 2000)

Program(s) to Serve Latinos and Other Communities of Color

CPCA has several ongoing initiatives designed to improve health care quality and access for Latinos and other communities of color.

Improved Access to Culturally & Linguistically Appropriate Services

Research and Publication

In order to improve the delivery of linguistically appropriate services, CPCA surveyed a representative sample of 50 CCHCs and chose 12 CCHCs to highlight as innovative models in providing language services. Because a geographically isolated rural health center may face very different issues than a large, diverse urban center, a variety of health centers were highlighted. These health centers illustrate the various approaches that organizations with differing circumstances have implemented.

The description of their innovative practices were compiled into the CPCA publication, "Providing Health Care to Limited English Proficient (LEP) Patients: A Manual of Promising Practices." Also included in this publication is an explanation of the federal requirements in serving LEP patients under Title VI of the Civil Rights Act and federal standards developed by the Office of Minority Health in providing culturally & linguistically appropriate services. A section highlighting the states that provide reimbursement for these services through the Medicaid and State Children's Health Improvement Program is also incorporated into the document.

This publication was developed to serve as a resource for CCHCs in California and across the country as well as other health care providers. Not only does it include descriptions of innovative models, but it also provides extensive resource material in the appendix to serve as templates for other health care providers.

"Providing Health Care to Limited English Proficient (LEP) Patients: A Manual of Promising Practices", with its descriptions of these practices, has received an incredibly positive response. Numerous individuals from organizations representing federal and state agencies, foundations, advocacy organizations, health care providers, and community-based organizations have requested copies. Due to the overwhelming response, CPCA has given out photocopied versions, referred people to download an electronic copy on our website, and has reprinted additional hard copies of the guide.

The Department of Health & Human Services, Office for Civil Rights, has recommended including CPCA's Promising Practice Guide as part of a technical assistance bulletin for federally-funded entities. Most recently, the guide was featured in The Commonwealth Fund's Report, "Providing Language Interpretation Services in Health Care Settings: Examples

from the Field," a national study of innovative methods for delivering language services.

Advocacy

CPCA has conducted extensive advocacy on both state and federal levels. On a state level, CPCA is co-sponsoring AB 982 (Firebaugh), legislation that would create a loan repayment program for culturally appropriate doctors and dentists to practice in medically/dentally underserved areas.

CPCA participated in the development and support of contract language outlining cultural and linguistic services in Healthy Families (California's State Children's Health Insurance Program) managed care plans in 1999. These policies include providing oral interpreter services for LEP patients, translating written documents for certain threshold languages, and conducting needs assessments of the health plan's patient population to determine cultural and linguistic needs. CPCA has continued its work in this area by supporting AB 2739 (Chan), legislation that would codify these contract requirements into statute.

On a national level, CPCA has advocated for a provision in S. 1533 that would provide $10 million to community health centers for language assistance services. CPCA has mobilized its clinic members to talk with Congressional members on the need for funding for these important services.

Administratively, CPCA has analyzed and developed comments on the republished Department of Health & Human Service Office for Civil Rights' guidance on serving LEP populations and mobilized clinic members to submit letters of support. CPCA also commented on the Department of Health & Human Services Office of Minority Health's Standards on Culturally and Linguistically Appropriate Services (CLAS), and advocated for the Medicaid managed care and State Children's Health Insurance Program regulations to include requirements to collect data by race, ethnicity, and primary language. In response to the Office of Management & Budget's study on the costs and benefits of implementing Executive Order 13166, CPCA was one of two provider organizations that emphasized the positive benefits of language services for improving access to health care, increased compliance with medication, and greater patient-provider trust.

Health Access to Immigrant Populations

Research and Publication

Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (welfare reform)[19] and the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (immigration reform)[20] created various barriers to health care access for the immigrant population. Since the passage of these Acts, CPCA has conducted extensive research on the impact of these initiatives on the immigrant population. CPCA documented the decrease in immigrant health care access to government sponsored heath care programs after welfare and immigration reform. In addition, CPCA documented the impact of this decrease on community and migrant health centers and their ability to serve this population. CPCA also researched state options and innovative methods for covering immigrant populations.

CPCA produced a policy brief entitled "Expanding Immigrant Access to Health Care Services". Sections I and II of the brief describe a) the recent changes in federal immigration and welfare laws, b) the state and federal options available to increase access to this population, and c) the advocacy and education roles for Primary Care Associations (PCAs) and community health centers (CHCs) in securing increased access. Section III focuses on innovative avenues available for expanding care to immigrant groups. The brief was created to assist other Primary Care Associations in advocating for immigrant health care access.

The advocacy strategies outlined in this document are based on successful models in California as well as CPCA's work. The brief also includes an analysis of California's Rural Health Demonstration Projects and other unique programs that assist health centers in securing health care access to immigrant populations.

Because of CPCA's efforts, including publishing "Expanding Immigrant Access to Health Care Services", CPCA has been recognized nationally for our work on immigrant access to care. CPCA has provided various trainings in California and nationally on complicated immigrant issues including public charge and welfare/immigration reform. Partners including the California Immigrant Welfare Collaborative and the National

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[19] Coffman, J., Rosenoff, E Grumbach, K, Center for California Health Workforce Studies, University of California, San Francisco. Explaining the Underrepresentation of Minoirites in Nursing: Disparity in Educational Attainment or Lack of Interest in Nursing Careers? Poster Presentation at the Association for Health Services Research Annual Meeting, Washington DC, June 2000

Pub. L. No. 104-193, 110 Stat. 2105 (1996), codified at 8 U.S.C. §1601 *et seq.*

[20] Pub. L. No. 104-208, 110 Stat. 3009 (1996

Immigrant Law Center to assist in their advocacy efforts have used CPCA's publication and advocacy documents.

Advocacy

CPCA has been involved in every initiative in California to assist immigrant populations in securing primary and preventive health care access. For example, federal law provides states with the authority to create state-only funded Medicaid and SCHIP services for all low-income immigrants by enacting a new state law after the passage of the 1996 welfare law. Approximately one-third of states[21] have adopted legislation that provides state-only Medicaid or SCHIP benefits for all legal permanent residents regardless of their date of entry. CPCA produced advocacy materials outlining the importance of this coverage and documented stories of individuals that would be adversely affected without this access.

For undocumented populations, CPCA has sought coverage where possible and access to care where coverage was not politically viable. CPCA has also worked to educate and advocate on the clarification of various barriers impeding immigrant access to care, especially "public charge", the fear by immigrants that they would be unable to secure legal permanent resident status if they used Medicaid. CPCA documented the impact of this issue and presented this information to Maria Echaveste, Deputy Chief of Staff for the Clinton Administration.

CPCA's advocacy on behalf of the immigrant community has helped secure health care access to various groups. California provides full scope Medicaid and SCHIP to all legal permanent residents. We do not implement a 5-year bar on new legal permanent residents. California provides full scope Medicaid coverage to "PRUCOL" immigrants and prenatal care to undocumented pregnant women.

In addition, CPCA has advocated for and implemented various innovative programs targeting farm workers and the children of farm workers. For example, the Seasonal Agricultural Migratory Worker (SAMW) program is a state-only funded program that provides health care services to California's farm workers. CPCA has successfully secured a $2 million augmentation to this program.

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[21] California, Connecticut, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and Wisconsin provide state-funded medical assistance (GAO, 1998). Alaska, Arizona, Illinois, Oklahoma, Tennessee, and Texas provide only state-funded prenatal care (GAO, 1998). California, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Nebraska, New York, Pennsylvania, Rhode Island, Texas, Virginia, and Washington use state funds to provide CHIP or Medicaid assistance to at least some of the legal immigrant children population (NCSL, 1999).

CPCA has also successfully sought the implementation of California's Rural Demonstration Projects. This program provides $3 million for targeted health care serves for the children of farm workers.

Health Education and Clinical Curricula

Orientation Manual for New Clinicians

CPCA produced a manual to assist clinicians who are National Health Service Corp scholars in becoming oriented to their placement sites within California community clinics and health centers. The manual includes a section on Cultural Competency and Diversity.

The section on Cultural Competency and Diversity is included to offer a brief overview of important concepts to help clinicians serve the increasingly diverse community of patients seen in California's community clinics and health centers. More than seventy percent of patients in California are members of minority racial or ethnic groups, and almost half claim English as their *second* language. The manual recognizes that diversity exists in many areas beyond racial differentiation. Consider the countless possible combinations of culture, religion, mental or physical ability, heritage, age, gender, sexual orientation and income level that an individual may embody.[1]

Healthy Newborns Program

CPCA's Healthy Newborns Program encompasses several different aspects. The first of which is a perinatal curriculum that was developed over the course of three years to provide community health center staff useful and relevant tools to teach perinatal education in an effective group session model. The curriculum includes a detailed teacher's guide and instructions and easily read patient materials. It is available in five languages including English, Spanish, Korean, Vietnamese and Chinese.

Second, the Healthy Newborns Project has developed and implemented a statewide educational media campaign to respond to the declines in perinatal visits reported by community clinics and health centers throughout the state. The campaign addresses the importance of perinatal care and urges women to seek these and other health care services in the nearest community clinic or health center. Culturally and linguistically appropriate motivational public service announcements have been produced in Spanish and English for television and radio. The announcements advertise CPCA's multi-lingual toll-free clinic referral service.

This referral service is staffed by operators who utilize CPCA's database to determine the clinic or health center closest to the caller that provides the requested health care services in the language required. Matches are first sought based on caller's residential zip code. If no match is found at the zip code level, the operator seeks a match within the city of residence or the nearest city. If no match can be made at the city level, the operator then searches the database for a match within the county of residence. Callers are given the name, address, and phone numbers for all community clinics and health centers in their area that can meet their needs. If no community clinic or health center is identified, a referral is given to the county health system. No identifying information is requested of the caller other than their zip code.

Special Programs for the Uninsured:

CCHCs are open-door providers who see anybody regardless of ability to pay. Because of this policy, CCHCs are the safety net providers of their community and often see large numbers of uninsured patients.

In addition to the initiatives described above, CPCA also advocates for the Expanded Access to Primary Care (EAPC) program. This state program provides critical funding to CCHCs for seeing uninsured patients. Because approximately 6.8 million Californians are uninsured, EAPC is an essential program for ensuring clinics can provide health care services to this population.

LEGISLATIVE ADVOCACY

LATINO COALITION FOR A HEALTHY CALIFORNIA

The Collaborative to Increase the Number of Latinos in the Medical and Dental Professions

A "Health Professions Pipeline" for Latinos is needed to dramatically increase the number of Latinos in health professions in California especially those providing medical and dental services. The shortage of these professionals exacerbates an already serious health access problem for California's Latinos. The percentage of Latinos among students applying to, matriculating at, and completing medical or dental schools in California has been historically low and has also declined in recent years. Since 1985, a majority of Latino medical students originally residing in California attended medical schools outside of California. Those who left the State remained in the state in which they completed medical school, further exacerbating the problem of Latino physician shortages.

To begin to address this problem the Latino Coalition for a Healthy California (LCHC) convened a group of proactive organizations to address this issue. The LCHC facilitates and administratively supports monthly meetings of the Collaborative to Increase Diversity in the Health Professions (Collaborative). The Collaborative is made up of representatives from a powerful group of statewide organizations. The Collaborative includes representatives from the California Medical Association (CMA), California Medical Board (CMB), California Dental Association (CDA), California Latino Medical Association, California Primary Care Association (CPCA), California State Office of Health Planning and Development (OSHPD), the Department of Consumer Affairs (DCA) and LCHC. The goals of the Collaborative are to:

- Outreach to and working effectively with community organizations serving the same populations they serve.
- Increase the representation of Latinos in the health professions in California, especially among physicians and dentists;
- Increase the number of Latinos in the health professions practicing in medically under-served areas where Latinos make up a substantial part of the population.
- LCHC and the Collaborative will engage in a three-pronged approach to achieve the stated goals of the Collaborative. This three-pronged approach involves:
- health policy research,[22]
- education on well-researched policy options targeting institutional, regulatory, administrative and legislative bodies, and

[22] Throughout this application the term research is defined as short, quick studies

- education on well-researched policy options targeting constituents and stakeholders.

Background

In California and elsewhere in the United States, the under-representation of Latinos in the health professions undermines the expansion of health access for the fast-growing Latino population. This under-representation also undermines Latinos being able to receive the benefits of cultural competency and appropriate linguistic capacity in the provision of health care. In California Latinos represent 32% of the population and their representation among Californians is increasing. The very concept of multicultural health as an objective is at risk of not being fully realized if a 'Health Professions Pipeline' for Latinos is not developed and supported. This pipeline is needed to dramatically increase the number of Latinos providing medical and dental services especially. The shortage of these professionals exacerbates an already serious health access problem in California evidenced by the existence of a large number of federally designated medically under-served areas (MUA) and populations (MUP) in California.

The problem of the under-representation of Latinos in the health professions is well documented, as are the potential benefits of a multicultural health environment, characterized by cultural competency and appropriate linguistic capacity to serve racial and ethnic minorities. The percentage of Latinos applying to, matriculating at, and completing medical or dental schools in California has been historically low and has also been declining in recent years. The trend of Latinos not completing medical school also appears to be part of a larger trend observed in a recent study by the Pew Hispanic Center entitled "Latinos in Higher Education: Many Enroll, Too Few Graduate."[23]

Four percent of physicians actively practicing in California in 1998 were Hispanic/Latino and three percent were Black, much lower than the percentages of Hispanic/Latinos and Blacks in the general population, 32% and 7% respectively.[24] In 1997, the number of medical school degree recipients who were Latino was 12.3%, reflecting less than half of the 32% proportion of Californians who are Latino.[25] Whites and Asian Pacific Islanders combined to constitute 89% of all recipients of

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[23] R Fry, Latinos in Higher Education: Many Enroll, Too Few Graduate, Pew Hispanic Center, Washington, DC, September 5, 2002.

[24] American Medical Association, Bureau of the Census; Bureau of Health Professions National Centers for Health Workforce Information and Analysis. HRSA State Health Workforce Profiles - California. Health Resources and Services Administration, US Department of Health and Human Services, Rockville, MD. December 2000.

[25] Dower C, McRee T, Grumbach K, Briggance B, Mutha S, Coffman J, Wranzian K, Bindman A, O'Neal E. The Practice of Medicine in California: A Profile of the Physician Workforce, San Francisco, CA: California Initiative at the UCSF Center for Health Professionals. February 2001.

dentistry degrees in California in 1997. Only 7.7% of Latinos were recipients of dentistry degrees during the same period.[26] In 1990, there were fewer Latino medical students per Latino population than there were in 1970. The elimination of affirmative action in state colleges and universities will exacerbate this trend.[27] A total of 440 of California's residents (medical) in 1999 identified themselves as Latino. This comprised only 5.4% of all California medical residents. [28]

A recent report, "Holding onto Our Own, Migration Patterns of Underrepresented Minority Californians in Medicine," by UC San Francisco, Center for Workforce Studies, points to other trends that compound the problem.[29] The study found that since 1985, a majority of Latino medical students originally from California attended medical schools outside of California. These findings not only indicate that Latinos are represented in small numbers in California medical schools, but that for more than a decade they have been going to medical schools that are out of the State of California.

This problem of out-of-state education has not previously been considered nor defined as a major problem. The trend has great negative implications because it was also found that those leaving the State remain in the state in which they complete medical school, further exacerbating the problem of Latino physician shortages. Health policy research is needed to identify options that support the recruitment and retention of Latino candidates for medical school in California, and for ways to entice them to serve in California MUA and MUP.

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[26] Source: *Bureau of Labor Statistics; Bureau of the Census; Bureau of Health Professions National Center for Health Workforce Information and Analysis.* HRSA State Health Workforce Profiles - California. HRSA Administration, US DHHS, Rockville, MD, December 2000.

[27] Hayes-Bautista, DE, Hsu, P, Beltran R, Villagomez J., (1999). The Latino Physician Shortage in California. UCLA Center for the Study of Latino Health and Culture.

[28] Coffman J, Levin R, Colburn L, Brumback K. Holding Onto Our Own: Migration Pattern of Underrepresented Minority Californians in Medicine, Center for California Health Workforce Studies, www.ucop.edu/cprc/medmigraton.pdf

[29] Coffman J, Levin R, Colburn L, Brumback K. Holding Onto Our Own: Migration Pattern of Underrepresented Minority Californians in Medicine, Center for California Health Workforce Studies, www.ucop.edu/cprc/medmigraton.pdf

AB 982 (Firebaugh) Health Care

The first project the group undertook was the development of a loan forgiveness program to attract physicians and dentists to work in underserved communities. As a result, in October 2002 the launch of a new program that encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their medical school loans in exchange for their service in a designated medically underserved area for a minimum of three years. Applications for the program are now available online at www.medbd.ca.gov/mdloan.htm. The California Physician Corps Loan Repayment Program was created by Assembly Bill 982 (Firebaugh) and became law on January 1. The Medical Board of California, the California Medical Association, the California Primary Care Association, and the Latino Coalition for a Healthy California co-sponsored AB 982 and worked closely to achieve its passage.

The population of California's medically uninsured now stands by some estimates at over seven million residents. In its recently developed Strategic Plan, the Board notes that various issues can limit access to critical medical services. There is not a direct statutory charge that the Medical Board address the problem of access to care, but it recognizes its obligation to participate in the search for opportunities to expand the availability of healthcare services.

The enabling legislation and the program that it spawned recognizes the necessity of improving conditions, which lead to healthcare disparities in the state, including those arising from cultural and linguistic barriers. At the same time, there is an acknowledged difficulty for many culturally or linguistically competent physicians to practice in underserved areas because of the heavy debt load that they carry from acquiring a medical education. Therefore, the loan repayment program seeks to match qualified physicians with clinics in need of their medical services and their understanding of the language and culture of populations served by that clinic.

In addition to earning a salary, physicians participating in the program will be eligible for loan repayments of up to $105,000 each, paid from specially established funds within the Medical Board. The new law requires that most participants be selected from the specialty areas of family practice, internal medicine, pediatrics, and obstetrics/gynecology; however, up to 20% of the participants may be selected from other specialty areas. Those participants who receive an award will work in clinics located in medically underserved areas, offering healthcare to underserved and uninsured populations.

A companion program is being developed to mirror the Medical Practice Act for Dentists, which will be under the auspices of the California Dental Board. The monies to fund this program ($3 million each) came from the Medical and Dental Boards of California.

For additional information on this new program and to download an application, visit www.medbd.ca.gov/mdloan.htm.

The Latino Coalition for a Healthy California continues to convene and lead the "Collaborative" and their work will continue to define and implement strategies to increase the number of Latinos in the medical and dental schools in California.

AB 2739 (Chan) Partnerships

Project Description

Cultural and linguistic services (C/L) requirements now apply to the HMOs that participate in California's Medi-Cal (Medicaid) and Healthy Families (SCHIP) programs; however, they appear only in the contracts that the HMOs have entered into with the state. The contracts are three-year contracts and are thus subject to change and negotiation before each new contract term. A.B. 2739 sought to: (1) codify in state statute the C/L requirements; (2) make the C/L requirements between the two programs more uniform; and (3) add a reporting requirement -- the HMOs would report their compliance to the state regulators; the state regulators would in turn report to the state's legislature. The five C/L areas, which A.B. 2739 would have codified, are: (1) Oral interpretation services at all key medical and non-medical points of contact (both between the patients and their medical care providers and between each program's beneficiaries and the program); (2) Written translation of vital documents into threshold languages; (3) Establishment of a community advisory committee; (4) Conducting of a group needs assessment; and (5) Cultural competency training of HMO staff and providers.

Process

The Asian and Pacific Islander American Health Forum, along with six partner organizations, Asian Pacific American Legal Center, California Primary Care Association, California Pan-Ethnic Health Network, Fresno Health Consumer Center of Central California Legal Services, Latino Coalition for a Healthy California, and National Health Law Program, had been monitoring the state regulators' and the HMOs' compliance with the C/L requirements and had analyzed other states' approaches to reimbursing for interpreter and translation services. In mid-2001, the partners began exploring specific legislative strategies, which led to the

drafting of legislative bill language, on that would have provided for reimbursement of interpreter services in the fee-for-service portion of Medi-Cal and the other that would have added new C/L requirements while establishing the existing ones.

However, in late-2001, the partners learned of the tight state budget situation and recognized that any legislative proposal, which entailed costs to the state, would not likely pass. The partners agreed to move forward with A.B. 2739, which would codify the existing contract requirements and add a compliance report requirement. In shepherding the bill through California's legislative process, the partners, along with the bill's author, Assemblywoman Wilma Chan (D-Oakland) and other supporters (health, immigrant rights, ethnic, civil rights and interpreter groups) handily got the bill through the health policy and appropriations committees of both the state's Assembly and Senate chambers.

The bill did face opposition from the medical care providers and the HMOs, which expressed concerns about the detail of the C/L requirements in the bill and the wording of some of the requirements (even though the requirements and their wording already appeared in the HMOs' contracts with the state). Moreover, the state regulators responsible for the Med-Cal and Healthy Families programs expressed concerns about the bill limiting their ability to be flexible in the C/L requirements with the HMOs and about the additional reporting requirement.

Negotiations ensued, the bill was amended three times, and, as the bill cleared the state legislature, it had picked up the support of the California Medical Association and the Local Health Plans of California (the association representing the most affected HMOs). Additionally, the state regulators had represented their main concern, the new reporting requirement, had been addressed with the amendment that removed it. The Governor then vetoed the bill, noting that he believed that the C/L requirements should remain requirements at the contract level.

Partners:

The seven partners brought different strengths to the legislative process, while remaining together supporting the bill to the end. Four were actively involved in the negotiations with the HMOs and the state regulators and the amendments to the bill. All wrote letters of support and, where there was the opportunity, encouraged their members, constituents and others to write letters of support. Two met with the legislators themselves. All were present at one or more of the hearings to provide testimony.

This is not to say that the partners did not face any challenges. At the outset of the bill process, in late-2001, the partners had met to discuss: how they would respond to the inevitable compromises that they would be called upon to make to the bill; who would serve as the spokesperson for the partnership; and what actions and decisions that spokesperson could take and make. In hindsight, the partners could have been more specific. In the heat of the legislative process -- whether in negotiations with the state, with potential opposition, with legislators themselves, or whether in deciding whether any amendment to the bill breached a "bottom line" on the bill – it was sometimes difficult to get all the partners to weigh in and not always easy to communicate (or even follow) all that was going on. Added to the mix was the strong role that the author played – the author's staff was very involved in the legislative process and instrumental in moving the bill along as far as it got.

Outcome

The Governor vetoed the bill on September 22, 2002. He indicated in his veto message that he preferred the C/L requirements to remain contract requirements because that provided flexibility in amending or strengthening them.

The outcome for the partnership is a different one. Each partner now appreciates the demonstrated strengths of the others. However, the partners also understand that the more preparation that could have been made at the beginning, particularly with regard to the "process" issues, would likely have made it easier. The partnership has met since the bill was vetoed to discuss future plans. The partners plan to stay together, to fight new fights as partners, but to hopefully do it having grown from the experience with the bill.

OTHER CLAS LEGISLATION

There is other legislation in progress at this point in time in California that in some way or another strives to address issues related to culturally and linguistically appropriate services (CLAS). The following list is an indication of the breadth and scope of these initiatives. It is a small indicator of the interest and legislative concern on the issue.

Government Agencies

AB292 (Yee) Interpreters

Prohibits the use of children as interpreters by government agencies and recipients of state funding.

SB973 (Yee) Interpretations Services

Requires the Dept of Consumer Affairs to compile information for other state agencies about interpreter services.

AB566 (Yee) Fish and Accounting Services

Eliminates requirement that certain record keeping by commercial fishers and retail fish sellers be done in English.

SB1471 (Haynes) Safety in Employment

Deletes the language access requirements applicable to Cal-OSHA from AB2837 passed last year

HEALTH SERVICES

AB154 (Chan and Firebaugh) Health and Managed Care Plans

Requires managed care plans in Medi-Cal and Healthy Families, as well as DHS and MRMIB to report on their cultural and linguistic services provided to beneficiaries. Sponsors are the Latino Coalition for a Healthy California and the Asian & Pacific Islander American Health Forum.

SB853 (Escutia) Health Care Language Assistance

Directs the Dept of Managed Health Care to issue regulations requiring health care service plans and specialized health care service plans to assess subscriber needs, and to provide translation, interpretation, and culturally competent medical services. Co-sponsors: CPEHN, MALDEF, and Western Center.

AB 801 (Diaz) Dentist, Physicians, and Surgeons

Creates a voluntary program to develop educational classes to teach foreign languages and/or cultural practices and beliefs that impact health care to interested physicians. The funding for this program would come from fees collected from the participants as well as the local medical societies.

CONSUMER PROTECTION

SB584 (Alarcon) Advertizing

Requires any business that markets in a non-English to make available upon request written materials describing the key sales terms of its products/services in the non-English language.

AB309 (Chu) and SB146 (Escutia) Contracts: Spanish Translation
Collectively close a loophole in existing law by (1) extending California Civil Code Section 1632 consumer protections currently available to Spanish-speaking individuals to include Asian language and other non-English speakers and (2) clarifies the terms that have to be translated. Co-sponsors: APALC, CAA, and MALDEF.

AB 534 (Vargas) Immigration Consultants: Client Protection
Prohibits an immigration consultant from working until he/she has registered with the Department of Consumer Services as an immigration consultant and obtained a general business license. It also requires the consultant to provide to the client a written translation of the contract into the client's native language.

FINAL COMMENTS

It was intended that those who read this find a level of guidance on how to approach the growing diversity in their communities. Whether the reader is an advocate, community based organization leader, a provider of services either in solo practice or as a member of a health care team that is struggling to meet the needs of Limited English Proficient populations, there should be something of interest. It is hoped that the words of those who struggle to meet the needs of communities of color and the examples of the programs presented herein will inspire others to take on the challenge and reward of serving those who need them most.

Salud para todos,

Lia Margolis, President & CEO
Lia Margolis & Associates

ABOUT THE AUTHOR

LIA MARGOLIS, PRESIDENT AND CEO

Lia Margolis & Associates

Born and raised in poverty in East Los Angeles, Lia Margolis knows first hand what it is like to seek access to care without resources. One of ten children, she was taken out of school at the age of 13 to help support the family, returning several years later to become the only one of ten siblings to go on to college for a degree in Business.

Lia Margolis & Associates (LM&A) was established in 1998 offering expertise in healthcare management, experience in serving communities of color and consensus building and conflict resolution skills. LM&A has gained respect and built a reputation for effective, quality professionalism with government, corporate, community based and non-profit organizations.

Having enjoyed a successful career Ms. Margolis felt a personal commitment to "give back to the community." For two and one half years she served on a "pro bono" basis with the Latino Coalition for a Healthy California. Recently, she returned to her consulting firm providing services to a wide range of clients.

Lia Margolis was appointed as the President and CEO of the Latino Coalition for a Healthy California and quickly moved the organization to the forefront in policy and consensus building in Sacramento. In her short tenure, she took the LCHC to heights never imagined and secured the LCHC's status as the leading voice for Latino health in California. Prior to joining LCHC Ms Margolis served with great pride in executive posts with the Los Angeles County Health Department to include Associate Executive Director, LAC+USC Healthcare Network one of the largest public health components of the LA DHS and in the nation.

She also served as hospital administrator, health center CEO for 12 health centers in East LA. She completed major projects that provided access to care to a constituency that was largely Latino including:

- The establishment of the Harbor/UCLA Medical Center MRI Clinical Research Center

- As Chief of Administrative Services, Public Health, LA County, administered millions of dollars in public health and community outreach contracts.
- The LAC+USC Neonatal Intensive Care Nursing Care Training program
- Healthy LA 2000 coordinating outreach with over 500 agencies and community based organizations
- Public Health Week that is now celebrated every year in Los Angeles and in 42 states nationally, and
- A full-scale marketing/media plan to include implementation, to provide health information and access to care for the uninsured in the Central and Eastern portion of Los Angeles.

Lia has received numerous awards for community advocacy and is most proud of the American Public Health Association, Latino Caucus Community Service Award, the California Latino Medical Association and the most recent National Hispanic Medical Association Award. Ms. Margolis has appeared on televised programs, presented in national conferences and she has produced several videos on health promotion and access to care. She was featured in Latina Style magazine, and has been published in JCAHO, LACMA Physician Magazine and has written several chapters in nationally recognized books, articles and publications. She serves on several statewide health committees, legislative Task Forces and federal Advisory Committees. She was also on the Program Committee, DHHS Office of Minority, National Health Disparities Summit that drew over 2,400 participants to Washington DC in July 2002.

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